

2016

What influences industry to offer clinical placements for pre-registration nursing students?

Justine Mercia Connor
University of Wollongong

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What influences industry to offer clinical placements for pre-registration nursing students?

By

Justine Mercia Connor

Summited in the fulfilment of requirements for the degree of

Master of Philosophy

University of Wollongong, NSW

April 2016

Abstract

Nursing has always been an occupation where students require substantial levels of clinical placement and professional experience prior to registration. Nursing education is now undertaken at a tertiary level in Australia and students are required to complete no less than 800 clinical placement hours during their pre-registration degree. Without clinical placements, student nurses cannot learn practical skills in an authentic world setting.

The aim of this study was to develop a substantive theory that presents an understanding of the factors that influence clinical placement providers to offer clinical placements for pre-registration nursing students and concomitantly to contribute to an understanding of why clinical placements are not offered.

The study used a qualitative approach and was guided by a Grounded Theory methodology. Semi-structured interviews were undertaken with nine persons who self-identified as the person who made the decisions to accept or decline pre-registration nursing student clinical placements. Analysis of the data was based on the Grounded Theory constant comparative method.

The resulting Grounded Theory for this Master's research is the theory of '**Relational Strength**'. This substantive theory asserts that the primary influence when offering clinical placement for pre-registration nursing students is the **Strength of the Relationship** between the universities and the Clinical Placement Provider (CPP).

Understanding the factors that influence CPPs to offer clinical placements for pre-registration nursing students will afford higher education and health service providers' valuable information to assist in ensuring appropriate clinical placements continue to be offered for pre-registration nursing students.

Without meaningful partnerships, offers of clinical placement can be impacted upon. Without clinical placements student nurses will not gain the clinical exposure that is required to prepare them to be safe and competent clinicians and meet regulatory requirements.

It is anticipated that the findings of this research will contribute to clinical placement availability through the development of strong beneficial relationships between pre-registration universities and clinical placement providers, ultimately impacting positively on overall clinical placement provision and contribute to enhancement of working relationships between universities and clinical placement providers within Australia.

Certificate of authorship and originality of thesis

The research and discussion presented in this thesis are the original work of the author and has not been submitted to any tertiary institution for any other award. Any material which has been presented by any persons or institute is duly referenced and a complete list of all references is presented in the reference list.

Signed and dated by Justine Mercia Connor

Justine Mercia Connor

Date: 10th July 2016

Copyright statement

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Acronyms, Initialisms and Glossary

A	
American Association of Colleges of Nursing	AACN
American Organisation of Nurse Executives	AONE
Assistant in Nursing	AIN
Australia	AUS
Australian College of Mental Health Nurses	ACMHN
Australian Health Practitioner Regulation Agency	AHPRA
Australian Institute of Health and Welfare	AIHW
Australian National Competency	ANC
Australian Nursing and Midwifery Accreditation Council	ANMAC
Australian Nursing and Midwifery Council	ANMC
Australian Qualifications Framework	AQF
B	
Bachelor of Nursing	BN
Billion	Bn
C	
Clinical Nurse Consultants	CNC
Clinical Placement Provider	CPP
D	

Director of Nursing	DON
E	
England	ENG
H	
Health Workforce Australia	HWA
Human Research Ethics Committee	HREC
I	
International Council of Nurses	ICN
M	
Memorandum of Understanding	MOU
N	
National Council for Accreditation of Teaching Education	NCATE
Nurse Educators	NE
National Health Service	NHS
National Health Service Plan	NHSP
National Health Workforce Taskforce	NHWT
New Zealand	NZ
Nurse Unit Manager	NUM
Nursing and Midwifery Board of Australia	NMBA
Nursing and Midwifery Workforce	NMW

Nursing Council of New Zealand	NCNZ
O	
Organisation for Economic Co-operation and Development	OECD
P	
Participant Information Sheet	PIS
Partnership Partnership may be described as a formal (sometimes legal) relationship existing between two or more entities contractually associated in a mutual undertaking.	
Personal Carer	PC
R	
Registered Nurse	RN
Relationship Relationship can be described as the way in which two or more entities behave toward and deal with each other. The formation and maintenance of genuine relationships should have moral value and a reciprocal influence.	
Royal College of Nurses	RCN
U	
United Kingdom	UK
United States of America	USA
University of Wollongong	UOW
W	
World Health Organization	WHO

Acknowledgements

This study would not have been possible without the input and support of many. Firstly and most importantly, the participants who voluntarily gave their time to share their thoughts and knowledge of the topic in an honest and open manner. Thank you.

My principal supervisor, Professor Lorna Moxham who kept me moving forward and therefore the study progressing, through her continuous energy and support. Her tireless revisions of my many iterations gave me exceptional guidance, her awesome humour kept me positive and her knowledge has helped me grow as a writer and researcher greatly!

My co-supervisor, Professor Kerry Reid-Searl whose continued support and encouragement allowed me to see this study was important within the discipline of nursing education. On the days when I needed a boost, hallway meetings that gave me bursts of validation and reassurance were just what was needed!

By urging me to have faith in the study and belief in myself, together they managed to guide me to completion of the project. The friendship that has grown during this process is a wonderful addition and for that I am so very grateful.

Finally, I would like to acknowledge and thank my support crew. My tolerant and loving partner Ross who always encouraged me to keep working on my research—even when I wanted to stop. My wonderful parents, Dale and Brendan, who have always taught me anything is possible. My fabulous children, Connor, Clayton, Patrick and Imogen, who at times did not get dinner at the appointed hour or picked up on time from school. Their support has allowed me this opportunity to complete a journey, I at times thought was not possible.

CHAPTER ONE

Research overview

The move from hospital based training to the higher education sector is asserted to have improved the professionalisation of nursing (Grealish & Smale 2011). That said, Gillett (2010) found that integrating nurse education into the higher education sector would, as anticipated, have implications for the relationship between universities that educate student nurses and health care facilities who accept student nurses for placement and ultimately employ them. The implications are particularly evident with regard to the requirement of education providers and provision of clinical placements in the health care sector, as a mandatory component of work integrated learning (Australian Nursing and Midwifery Accreditation Council [ANMAC] 2012).

This thesis presents a substantive theory explaining what influences industry to offer clinical placement for pre-registration nursing students. It is set out in a formalised manner, the format of which is elucidated shortly. Chapter one introduces this thesis; it presents the research purpose and aim, research question, rationale and significance of the study. The chapter asserts that the language used throughout the thesis, is a result of clinical placement provider's specific nomenclature. As such, a significant number of Australian health clinical placement provider's specific terms and language, will require explanation. The nuances and meaning of such prose often becomes apparent as a result of the narrative but to ensure clarity of understanding, words and phrases are also defined within the Acronyms, Initialisms and Glossary provided on pages ix–x.

One may question why pre-registration nursing clinical placements are important and why must we care about what influences industry to offer them to universities for Bachelor of Nursing (BN) students. The World Health Organization (WHO) avers that 'tertiary education be the global standard for nurse training' (WHO 2009). This is a goal to aspire to and in

many countries nursing education is already located within the higher education sector. Table 1 provides an example of when nursing education became part of the higher education sector for three countries.

Table 1: Commencement of nursing training to higher education sector (AUS, ENG & NZ)

COUNTRY	UNIVERSITY BASED EDUCATION	CONTEXT
AUSTRALIA	1984	Nurse education commenced in the tertiary education sector. (Aust. Gov. Dept. of Health 2013)
ENGLAND	1956	University of Edinburgh established the first nursing department in a European University, providing the first course for clinical nurse teachers. (Watson 2006)
NEW ZEALAND	1970s	Nursing training moved away from being hospital based in the 1970s, as students enrolled in universities or polytechnics to undertake nursing studies. (Healthtimes 2015)

Nursing, as an applied science, has always been an occupation where students require substantial levels of clinical placement and professional experience prior to registration. Nursing education is now undertaken at a tertiary level in Australia and students are required to have no less than 800 clinical placement hours (Health Workforce Australia (HWA) 2014a). Clinical learning can occur in both on and off campus settings. On campus settings are typically University facilities such as lecture theatres and classroom laboratories where theoretical concepts are learned. In contrast, the off-campus setting is generally a health care facility such as, a hospital or health centre, where students care for actual patients with existent conditions. The clinical placement experience for students is considered vital for developing professional competencies (HWA 2014a; Bisholt et al. 2014; Ha 2015; Lamont, Brunero & Woods 2015). Off campus placement experience, provide students the opportunity to integrate the practice of nursing theory in real life settings. Given the significance of the clinical placement within nurse education, the concept is worthy of exploration.

Research purpose

The purpose of this research is to contribute to the body of knowledge regarding pre-registration nursing clinical placements in the tertiary sector. At the University of Wollongong (UOW), undertaking a Master of Philosophy provided me, a novice researcher, an opportunity to pursue independent research (UOW 2015). The author took this opportunity to undertake a Master's by research. The outcomes of this opportunity are presented here in this thesis which offers valuable information and knowledge that enhances current literature. In fact, although a Master's and not obliged to do so, it contributes new knowledge and does so by examining the offering of clinical placements to pre-registration nursing students in Australia.

Research aim

The aim of this study was to develop a substantive theory that presents an understanding of what influences clinical placement providers to offer clinical placements for pre-registration nursing students. With the achievement of this aim, a substantive theory that explains the phenomena was developed.

Research question

The research question that guided this study was *What influences clinical placement providers to offer clinical placements for pre-registration nursing students?*.

What this Master's research contributes?

It is anticipated that the results of this study, in combination with the identified substantive theory, will provide insights for stakeholders into what is important for universities and Clinical Placement Providers (CPP) when considering clinical placement offerings. As a consequence, the number of clinical placements offered to pre-registration nursing students may increase.

Current demand for clinical placements appears to outstrip supply (Courtney-Pratt et al. 2012; National Health Workforce Taskforce (NHWT) 2009). Understanding the factors that influence CPPs to offer clinical placements for pre-registration nursing students will afford higher education and health service providers' valuable information to assist in ensuring appropriate clinical placements continue to be offered for pre-registration nursing students. Without meaningful partnerships, offers of clinical placement can be impacted upon. Without clinical placements student nurses will not gain the clinical exposure that is required to prepare them to be safe and competent clinicians and meet regulatory requirements.

Preparing registered nurses who are fit for practice, purpose and academic award is a key issue (ANMAC 2012). Such preparation can only be achieved through the continued offers of clinical placement for pre-registration nursing students from CPPs. This thesis found that it is

the **Strength of the Relationship**, developed through effective communication and by way of valuing and supporting each other, that meaningful partnerships can be developed. It is when the relationship between both the universities and the CPPs is strong, that mutual benefit occurs.

Organisation of the thesis

As suggested above, this first chapter provides an overview of the study including the research aim, research question, rationale and importance of the study. There are five additional chapters to follow. Chapter two presents background and contextual information in relation to historical training of nurses. The discussion in chapter two includes an exploration of the transfer of hospital-based training to tertiary-based education within Australia and its influence on the clinical practice of nursing students. Through engaging with the literature, confirmation that there was a significant scholarship gap in relation to what influences CPPs to offer clinical placements to pre-registration nursing students, was assured.

Building on the discourse in chapters one and two, chapter three explores the chosen research design and includes a comprehensive discussion regarding the methodology, namely, Grounded Theory. In addition, the research design chapter presents the methods that were used to collect and analyse data. Importantly, chapter three also presents some participant characteristics and offers an explanation with regard to the ethical considerations that were adhered to throughout the course of the research project.

Chapter four presents the results of the research. It includes extensive use of participant voices to illustrate the key concepts that were identified through the process of constant comparative analysis. The identified substantive theory is also presented in this, the findings chapter.

The substantive theory for this Master's research is the theory of '**Relational Strength**'. This substantive theory asserts that the primary influence when offering clinical placement for pre-registration nursing students is the **Strength of the Relationship** between the universities and the CPP.

Chapter five discusses the research findings presented in Chapter four and explores these in the context of existing literature. Findings of this research suggest that; universities need to have a strong relationship with their industry partners, the CPPs, to ensure clinical placements continue to be offered to them. Chapter six concludes the thesis, with the recommendations outlined in the narrative, aimed at promoting dual responsibility in the production of safe and competent graduate registered nurses.

The next chapter begins by discussing the historical and current landscape of nursing in Australia. The reader will gain an appreciation of the importance of the issue, as the chapter illustrates the demand for clinical placements. This is shown through an examination of the governance structures placed on pre-registration programs in order to meet accreditation purposes. Clinical placement holds such an important place within pre-registration nursing programs. The importance of ensuring that students have a clinical experience that will foster novice clinicians who value safety and knowledge, will positively contribute to public safety with the Australian health care system.

This introduction chapter has provided direction as to how the chapters of this thesis will flow. It has summarised each of the following five chapters and gives supporting information as the reader commences the thesis. To continue the Background and Context chapter is forthcoming. This will situate the research issue within the literature.

CHAPTER TWO

Background and context

Clinical placements afford student nurses opportunities to learn practical skills in an authentic world setting. James and Chapman (2010, p. 35) stated ‘clinical is the pinnacle’ when they investigated the clinical experience of pre-registration nursing students of an Australian University. They concluded that the clinical experience, together with student expectations and a respectable understanding of the profession of nursing, become pivotal in the pre-registration student’s journey (James & Chapman 2010). The aim of this chapter then, is to set the scene for the proposed research study that poses the question *What influences industry to offer clinical placements to pre-registration nursing students?* The chapter offers the background and context of this important study.

Firstly, there is an overview of what defines a professional nurse and then the chapter moves to include a discussion of the evolution of pre-registration nursing education in Australia. The chapter’s narrative then explains why there are so many students enrolled in Australian pre-registration nursing programs and illustrates the demand that clinical placement has within these baccalaureate programs. The final part of the chapter will explicate the importance of ensuring students have a clinical placement experience that will enable them to become safe and knowledgeable clinicians, thereby positively contributing to public safety within the Australian healthcare system. Currently there is little specific research into the influences and decision making when offering clinical placements to pre-registration nursing programs, thereby revealing a significant gap in the literature. This research will add valuable information in this area for the nursing profession.

The profession of nursing

The International Council of Nurses (ICN) is a federation of more than 130 national nurse associations worldwide and was founded in 1899. The ICN was the first international

organisation for health care professionals and defines nursing as a profession that ‘... encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings’ (ICN 2015, para. 1). Nurses and midwives are considered proficient health care professionals who combine the art of caring with scientific knowledge and skills (Bell, Campbell & Goldberg 2015). A registered nurse (RN) within Australia, is a person who has completed as a minimum, a three-year bachelor degree or equivalent, and is registered with the Nursing and Midwifery Board of Australia (NMBA 2015). Australian registered nurses and midwives are educated to provide services to ‘... promote, maintain and restore health and wellbeing’ (Australian Institute of Health and Welfare (AIHW) 2012, p. 4). RNs practise independently and interdependently, assuming accountability and responsibility for their own actions, including delegation of care to enrolled nurses and other health care workers (HWA 2014b).

Through a combination of theoretical content and practical experience, both within the University settings as well as during off-campus clinical experience in health care settings, a Bachelor of Nursing (BN) degree prepares the graduate to be a registered nurse. Nursing graduates are highly valued and may find employment throughout Australia and overseas in a variety of nursing positions and contexts (Scanion 2008).

The Australian Health Practitioner Regulation Agency (AHPRA) is the national organisation responsible for implementing the National Registration and Accreditation Scheme across Australia, in partnership with the National Boards. AHPRA’s operations are governed by the Health Practitioner Regulation National Law in each state and territory which came into effect on 1 July 2010 (AHPRA 2015). This law means that for the first time in Australia, 14 health professions are regulated by nationally consistent legislation under the National Registration and Accreditation Scheme. In terms of nursing, this board is the Nursing and Midwifery Board of Australia (NMBA 2015).

As guided by the National Law: AHPRA and the NMBA work to regulate the health professions, undertaken in the public interest. This includes ‘... registering practitioners who are suitably trained and qualified to provide safe healthcare, and investigating concerns about registered health practitioners’ (AHPRA 2015, p. 3). This allows AHPRA to ensure only practitioners with the correct qualifications and who are currently lawful to practice, are able to work in Australia.

The NMBA has established State and Territory Boards to support the work of the National Board. The functions of the NMBA (2015) include:

- registering nursing and midwifery practitioners and students,
- developing standards, codes and guidelines for the nursing and midwifery profession,
- handling notifications, complaints, investigations and disciplinary hearings,
- assessing overseas trained practitioners who wish to practise in Australia,
- approving accreditation standards and accredited courses of study.

The National Board sets policy and professional standards as per the noted functions, which are in turn supported by AHPRA. State and Territory Boards also support the National Board in their capacity to make individual notification and registration decisions affecting individuals.

In Australia, universities pay the health care industry to take nursing students on clinical placement. The total global expenditure for health professional education is about \$130 billion (bn) Australian dollars per year (US\$95bn, €86bn, £32bn) and remarkably this amount is less than two percent of health expenditure worldwide (Frenk et al. 2010). The investment in health professional education worldwide is insufficient to address need (Frenk et al. 2010). Nurse education has struggled within fiscally challenged environments particularly with regards to the actual cost of placing nursing students in clinical settings for their practical preparation.

This chapter began with an emphasis on the importance of clinical placements. In this regard the ICN (2009) suggest that the capacity of educational programmes to prepare clinically safe, competent nursing graduates is often jeopardised by: insufficient emphasis and time allocation for clinical learning, the absence of clearly defined clinical education outcomes, use of ineffective clinical teaching methodologies, unsuitable, poor quality or crowded clinical learning places and a lack of good clinical role models (ICN 2009). The interdependence of the health and education sectors, principally in relation to clinical placements, is paramount and a balance between the two systems is crucial for efficiency, effectiveness and equity (Frenk et al. 2010). As this thesis asserts in much greater detail later, this interdependence is underpinned by the need for collaborative relationships and to that end, the theory of ‘**Relational Strength**’ which is the major finding from this research, speaks to this interdependence.

The Registered Nurse Accreditation Standards require education providers to have clearly articulated models of supervision, support, facilitation and assessment in place so that students can achieve the required learning outcomes and meet the current National Competency Standards for Registered Nurses in Australia (HWA 2014b). Health professionals engaged in supervising and supporting students during workplace clinical experiences need to be adequately prepared for this important professional role and seek to incorporate contemporary and evidence-based Australian and international perspectives in nursing practice. The assessment of competence within the context of clinical placement needs to be undertaken by an appropriately qualified registered nurse (HWA 2014b).

The evolution of nursing in Australia

The context of nursing education in Australia since 1985 has been one of constant evolution. Nurse education moved from hospitals to the tertiary sector in Australia in the latter part of the 20th century (Kako & Rudge 2008; Brackenreg 2004). Preceding this time, nurse

education existed within a training-apprenticeship style system, located within training hospitals and health care districts. Within the hospital system, student nurses learned their trade under the supervision of the senior nursing staff, within a pedagogical model of ‘see one—do one’ (Kako & Rudge 2008, p. 143). Kako and Rudge (2008) further suggest that the skills that nurses learned, had little emphasis on problem solving or critical thinking, but rather skill sets were taught and based within a predominately medical model of healthcare system, under the guise of handmaiden to the doctors.

Nursing students were recruited directly by the hospitals in which they trained, maintaining a constant source of staffing across a wide scope of practice, having all year levels of nursing students undertaking workload in a progressive flow. A ‘... sense of belonging was strongly embedded as students socialised where they lived (in nurses’ quarters), where they worked and where they were educated’ (Mannix, Wilkes & Luck 2009, p. 60). New intakes (commencing nurses) were expected regularly throughout the year and came in manageable numbers for the wards to cope with. The intakes were scheduled and everyone knew when a new group was expected. They often arrived four times a year in batches of about 20–25 nurses. Senior students were often in charge of the ward in the evenings and on night shift. Although students did get to experience other health care facilities as a rule, the culturalisation into their training hospital was strong. Mannix et al. (2009) expresses that this was because students knew and understood their place within the wards, were accepted as an important and integral part of hospital life and were clearly identified as central to the nursing workforce.

As Dylan suggested in his hit song of 1964 ‘*The Times They are A-Changin’*’, times were changing for nursing in Australia. The first tertiary based nursing program was introduced in Victoria, Australia in 1974 (Happell 2009). Although tertiary education commenced at this time in Victoria, it was not until 10 years later in 1984 that the federal government announced

the transfer of nursing education into the tertiary sector at a national level. A year later, the mass movement from hospital based training to tertiary education began. Subsequently the full transfer of nurse education in Australia from hospital based training to the University sector occurred over a 10-year period from 1984 and was completed in 1993 (Happell 2009; Grealish & Smale 2011). Early in the transition process, higher education institutions and hospitals partnered at a local level. However, with partial deregulation of the higher education sector and increasing shortages of skilled nurses, many health agencies began to partner with multiple higher education institutions to meet demand for clinical experiences (placements) for nursing students (Grealish & Smale 2011).

Programs leading to registration as a nurse are developed in collaboration with key stakeholders, reflecting contemporary trends in nursing and education. Programs must comply in length and structure with the Australian Qualifications Framework (AQF) for the qualification offered, ensuring that graduates meet National Competency Standards (NCS) for the RN. Workplace experience needs to be sufficient to enable safe and competent nursing practice by program completion. Currently, clinical placement within the Australian Bachelor of Nursing (BN) curriculum, is a minimum of 800 hours of workplace experience (HWA 2014b), not inclusive of simulation activities, and is incorporated into the program over three years to provide exposure to a variety of health-care settings.

Initial education to gain qualification as a registered nurse is provided through universities and is usually three years of full-time study. Figure 1 as shown below, displays the primary education pathways leading to eligibility for registration as a registered nurse in Australia.

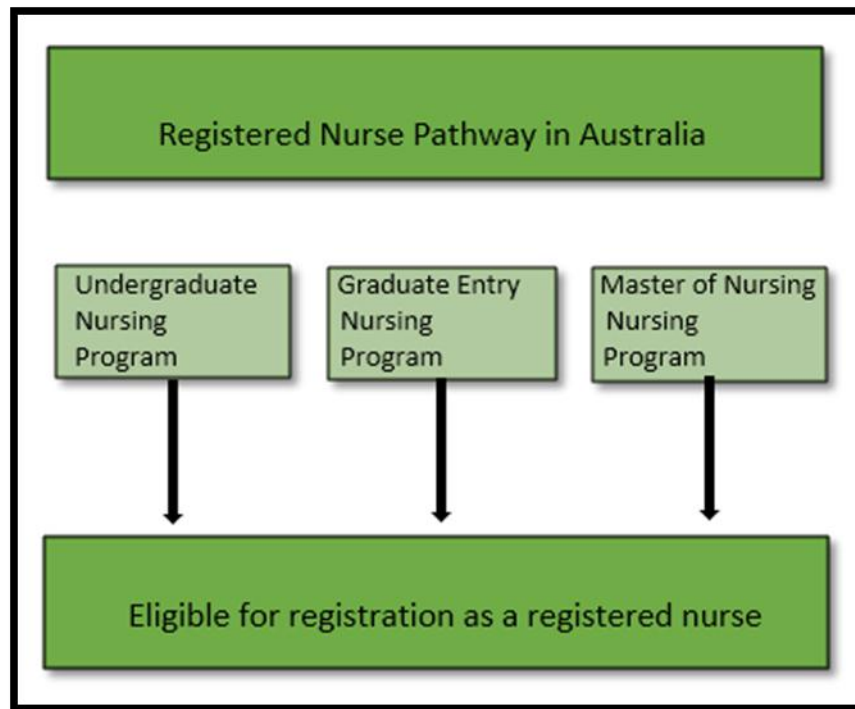


Figure 1: The primary education pathways leading to eligibility for registration as a registered nurse in Australia.

(adapted from HWA 2014b, p. 6)

In terms of numbers, the proportion of student commencements in BN courses dropped between 2003 and 2004, then showed a gradual increase through to 2010 (7,926 commencements in 2003 and 13,838 in 2010). Completions have also grown over the period (5,306 domestic completions in 2003 to 7,708 in 2010) as shown in Figure 2.

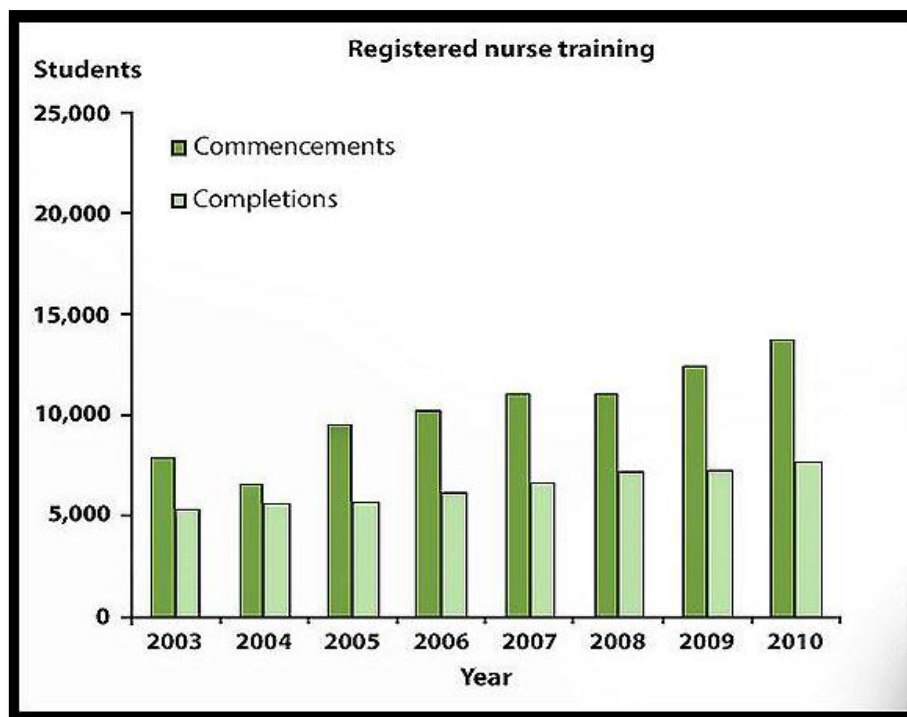


Figure 2: Number of domestic Australian student commencements v completions in BN courses 2003–2010.

(adapted from AIHW 2012, p. 48)

The data shown in Figure 3 below, presents all nursing programs offered in 2012 based on the amount of clinical training hours they require in comparison to the national minimum of 800 hours. Comparing programs, it is noted that some students were required to complete between 801 and 920 hours of clinical training, the latter being up to 15 percent more than the national minimum requirement. Ten nursing programs had clinical training requirements of exactly 800 hours (HWA 2012).

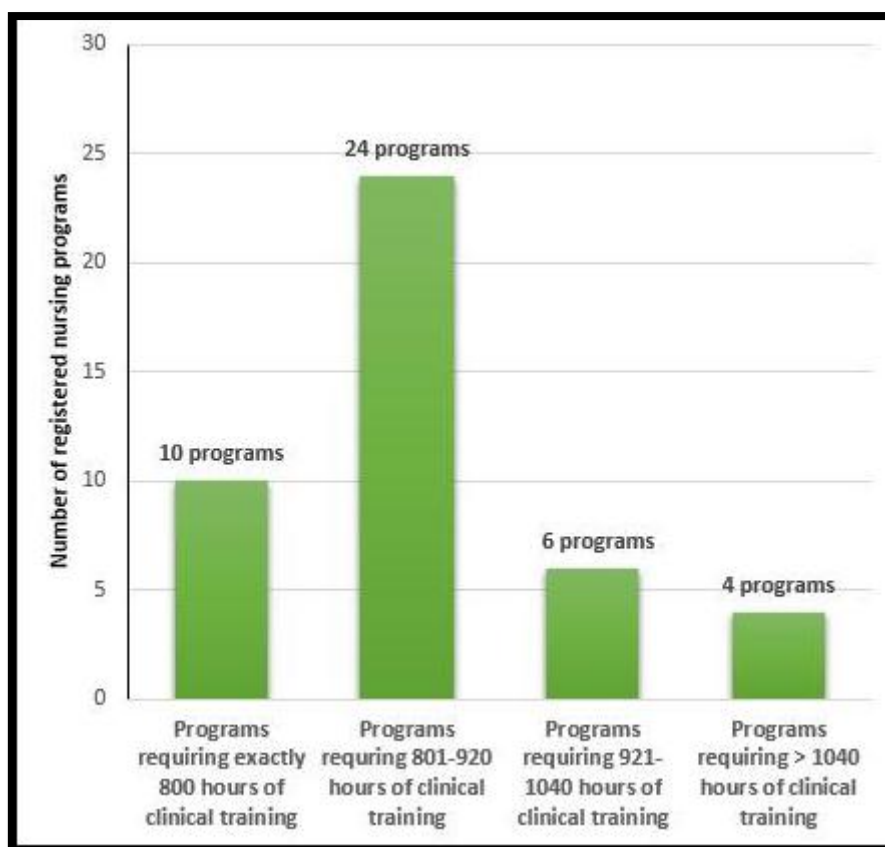


Figure 3: Nursing programs and clinical training hours—2012.

(adapted from HWA 2014b, p. 9)

The need to boost registered nurse numbers for the future

Nurses comprise a substantial proportion of the health workforce. In 2012, the number of nurses and midwives registered was 334,078. Of these, 237,699 were listed as a registered nurse, and 33,317 had dual registration (registered nurse and midwife) (HWA 2014b).

In the 2011 Australian Census, there were 257,200 nurses working in Australia, the majority of whom were registered nurses (80%). In addition, there were enrolled and mothercraft nurses (7%) and midwives (5%) (AIHW 2012). The increased demand for health services has put pressure on the sector. One of the main contributors to this pressure is Australia's changing demography, particularly an ageing population and an ageing health workforce (AIHW 2012).

The age distribution of nurses has changed over the past decade, with increased numbers of nurses in the older age brackets as shown below in Figure 4. In 2015, the general registrant count indicates nurses aged 55–59 years made up the largest age group followed by those aged 55–54 years.



Figure 4: RN registration by age group—Australia 2013.

(adapted from NMBA 2015, p. 9)

The demand for clinical placements.

The accreditation standards developed by the ANMAC specify a minimum number of clinical placement hours that a BN program must provide for it to be accredited as a program leading to initial registration as a nurse.

The main source of future generations of nurses is through preparation of new graduates. The time required for students to complete their RN preparatory education and enter the workforce is such that any acute change in the demand for nurses cannot be met by this group (AIHW 2012). In recent years, Australian governments have recognised the significant challenges that workforce shortages present to the quality and sustainability of Australian health care. A key strategy has been to train more health practitioners to increase workforce numbers. There have been substantial increases in professional entry University places, and an accompanying growth in demand for the associated clinical placements, requiring more

clinical supervisors. Barnett et al. (2012) reports that the workforce crisis mandates that universities increase the number of graduates from nursing courses.

However, Barnett et al. (2012) also asserts that in a practice-based profession any growth in student numbers is constrained by the ability of clinical venues to accept students for clinical experience. This assertion does of course, speak to the very point of this research. Indeed, clinical placements are getting harder and harder to procure in sufficient numbers.

The growth in demand for clinical placements is occurring within a clinical environment which is increasingly complex and changing. Workforce shortages, greater demand for clinical services, an increased acuity and complexity of patients (both in the hospital setting and the community) and resource constraints, all impact on the ability and willingness of clinicians to take on additional student supervision. This is of great significance as supervision is required when students are on clinical placement (Rodger et al. 2008).

Therefore, to continue to offer clinical placements for pre-registration nursing students there is a mutual challenge to universities and CPPs regarding how to expand student supervision capacity in an environment, where clinicians are already stretched to cope with service delivery pressures and their current student supervision load.

Clinical placements for pre-registration students are difficult to source in the current climate of resource and revenue limitations (Browne, Fetherston & Medigovich 2015). Despite this, academics, clinicians, and health care authorities all agree that a student's clinical placement is a crucial aspect of nurse education (Vinales 2015). Further to this, clinical placement for any health professional is paramount to gaining clinical competence, and the shortage of clinical placement availability is not just confined to nursing, but reaches far wider within the Australian healthcare landscape. Lack of work experience opportunities are an international

problem for all disciplines requiring clinical placement (Browne, Fetherston & Medigovich 2015).

An example of this is in pharmacy education. Smith et al. (2008) argue that significant changes in healthcare and the increased need for pharmacy professional practice experience opportunities, have presented new challenges for colleges of pharmacy and affiliated departments of pharmacy at academic medical centres. Pressures on health systems to reduce operating expenses, maximise productivity, and provide optimal patient care have led pharmacy administrators to closely examine the expenses associated with providing experiential education to pharmacy students. Similarly, Baldry-Currens and Bithell (2003) state the need to increase availability of practice placements for pre-registration physiotherapists in the United Kingdom to be paramount, particularly since higher student numbers had been commissioned with the implementation of the National Health Service Plan (NHSP).

The importance of clinical placement in pre-registration nursing

Nurse regulatory authorities (AHPRA, NMBA and ANMAC), educational institutions and health care providers all have a responsibility to the community to ensure that the graduates of nursing programs are safe and competent beginning practitioners (ANMAC 2014a). The move of nursing education to the tertiary sector was meant to ensure this (Brackenridge 2004). Mannix, Wilkes and Luck (2009) prompts us, that an important way to ensure this is enabling students to have a beneficial clinical placement experience.

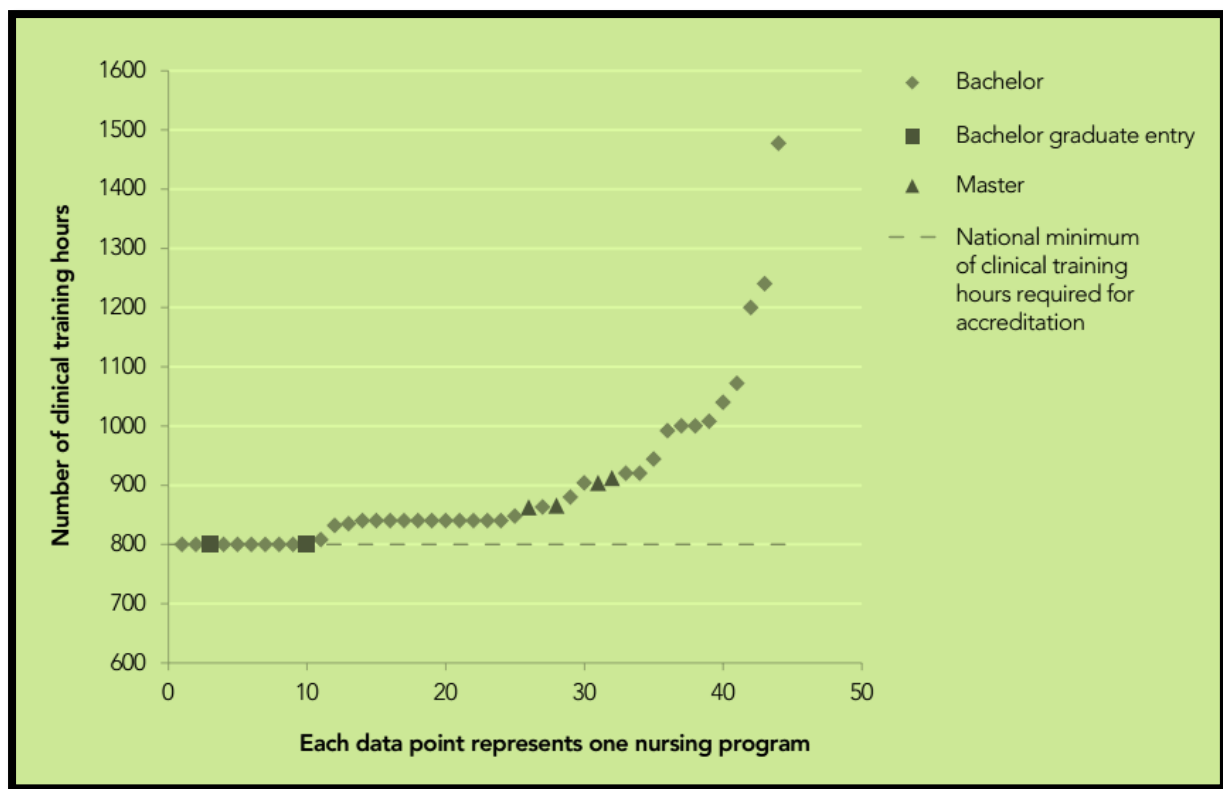
At the risk of labouring the point, but a point that is integral to this research is that nursing is a discipline that requires substantial levels of clinical training prior to registration (HWA 2014b). Professional experience or clinical training in the health care context is vital for developing professional competencies. It is also important for promoting cultural acclimatisation to the realities of nursing work. Clinical placements involve nursing students

working under supervision in a specific health-care context, with the aim of providing the link between theoretical knowledge and practical application in a supportive environment (HWA 2014b).

Clinical placement comprises over 40 percent of total course time for students in programs of study that lead to eligibility for registration as a RN in Australia (HWA 2014b). Clinical placements often begin in the first academic year of study and continue throughout the three-year program, with the number of clinical days increasing with each training year (Gilbert & Brown 2015).

Levett-Jones and Bourgeois (2011) emphasise that effective clinical placements across a range of venues are vital to the development of competent and confident professional nurses. Learning in the clinical environment provides the real world context for nursing students to develop the knowledge, skills, attitudes and values of a registered nurse. Students have experiences on clinical placements that cannot be fully authentically provided in a classroom or laboratory setting.

Mandatory clinical hours are required by the governing bodies (HWA 2014b) and some universities offer more hours than the minimum. When universities do this, they are forced to find greater clinical placement capacity. Figure 5 below depicts the range of clinical hours across 44 different nursing programs leading to registration as a registered nurse. Data shows how clinical placement ranges between 800 and 1,478 clinical training hours. The overall average is 899 hours. This is 12 percent above the mandatory minimum number of clinical training hours. For the data analysis, ‘nursing program’ was defined as nursing training delivered in Australia that on completion leads to eligibility for registration as a nurse.



recognise and feel comfortable with the unfamiliar setting of the health care facility (El Haddad, Moxham & Broadbent 2013).

There is growing recognition that sufficient, adequately trained and motivated health workers are essential for the health of the world's population. Equitable access to necessary health services of good quality cannot be achieved without an adequate number of appropriately prepared nurses given their significant numbers within the clinical workforce. Clinical experience through clinical placement is essential.

As noted in a study from the United States of America (USA) by Buerhaus et al. (2009), the total number of full-time equivalent RNs per capita was forecast to peak around the year 2007 and decline steadily thereafter as the largest cohorts of RNs retire. By the year 2020, the RN workforce is forecast to be roughly the same size as it is today, declining nearly 20 percent below projected RN workforce requirements. This declining USA nurse situation can be seen in all Organisation for Economic Co-operation and Development (OECD) countries, including Australia. This is predicted to be between 22 percent and 29 percent globally (OECD 2013). The gap in supply identified by OECD could be filled by migrant nurses from elsewhere in the global health system. Indeed, in a report written for The Royal College of Nurses (RCN) and titled '*Overstretched. Under-resourced: The UK nursing labour market review 2012*', it was already indicated, Australia, Canada and the USA would see their future skills gap being filled by nurses from outside their own borders (Buchan & Seccombe 2012). There are though, ethical considerations regarding this, but this will not be examined in this thesis.

Newly graduated registered nurses often lack confidence in professional practice (Pfaff et al. 2014). Academic institutions and health care institutions ought to partner in the development of knowledge and experiences in interprofessional collaboration for nursing students and new

graduate nurses (Pfaff et al. 2014), a notion that will be espoused later in this thesis. To meet this, clinical practice is an essential part of the nursing students' education with this only being achieved through clinical placements. Clinical placements facilitate students' opportunities to link theory with the practice of caring for people.

Chapman and Orb (2001) noted 15 years ago that the clinical setting is fundamental to nursing students learning, because it offers opportunities for them to work with *real* patients with *real* problems. It is in the clinical setting that student nurses can use knowledge in practice, develop competency in psycho-motor skills and become socialised in their future role. Clinical placement assists students in consolidating their knowledge by getting hands on experience and practising what they were taught in the nursing laboratories (Chapman & Orb 2001).

The main function of nurse education is to graduate RNs who have the ability and knowledge to care for patients in a variety of settings. The act of caring for *real* patients cannot be simulated in a laboratory setting, nor can the practice of communicating with people who are sick, distressed, suffering, afraid and anxious. Students of nursing gain these experiences by attending clinical practice (Chapman & Orb 2001). Given that the clinical component of nurse education is crucial to the future practice of the graduate nurse, the quality of this experience is paramount.

Pfaff et al. (2014) suggests that clinical education is crucial in the consolidation of students' learning but in these times of economic rationalisation, clinical placements for students appear to be an expensive luxury. Despite purported economic constraints, clinical practice is shown to be an essential component of pre-registration nursing students learning. The nursing profession, including universities and clinical placement providers, must commit itself to a high level of clinical practice for students of nursing.

Now the context has been described, the question for this thesis, *What influences clinical placement providers to offer clinical placements for pre-registration nursing students?* will be clarified in the findings and discussion chapters to follow.

This chapter described the background and context to situate the proposed research study which was guided by the research question *What influences industry to offer clinical placements to pre-registration nursing students?* The chapter provided an overview of professional nursing and included a description of the evolution of pre-registration nursing education in Australia. It rationalised why there are so many students enrolled in Australian pre-registration nursing programs and illustrated the demand clinical placement has within pre-registration nursing programs. The chapter concluded by exploring the importance of ensuring students have a clinical placement experience that will enable them to become safe and knowledgeable clinicians, thereby positively contributing to public safety within the Australian healthcare system.

CHAPTER THREE

Research design

The following chapter introduces the research methodology used for this study. It will explain the rationale for adopting Grounded Theory as the methodology, and why this is an appropriate approach in answering the research question *What influences industry to offer clinical placements for pre-registration nursing students?*.

Further discussion in relation to research design, including the researchers' relationship to the study, ethical considerations, participant selection and recruitment, data collection and analysis are included. The use of constant comparative analysis is discussed whereby the primary method of analysis is a continuous coding process, commencing with open, then axial and finally selective coding. A summary of key points inclusive of theoretical sensitivity, and the importance of rigour in data analysis, concludes the chapter.

The researcher's relationship to the study

The researcher has a twenty-year history of working as a registered nurse within Central Queensland regional health care district in public, private and independent health care facilities. Roles and responsibilities within these areas have included clinical care of the patient, clinical teaching and facilitation of nursing students, nurse education of hospital employees and after-hours management of a health care facility. Therefore, the researcher brings with her an array of nursing knowledge and experience in a variety of roles. To some, this could be thought of as bias, but as Strauss stated (1987, p. 11) '... mine your experience, there is potential gold there!'.

The concept of bias can be somewhat problematic when referring to qualitative research, since by definition the qualitative researcher is part of the process and all researchers are diverse. Unlike positivist (traditional) research, Morse et al. (2009) argue researcher bias need not be avoided or feared but should be welcomed. Rajendran (2001, p. 2) reflects

‘... qualitative researchers try to acknowledge and take into account their own biases as a method of dealing with them. They attempt to seek out their own subjective states and their effects on data, but they never think they are completely successful’. This is particularly true when the data must iterate through the researcher’s mind before it is authenticated on paper and the concern of subjectivity arises.

This inclination called bias is a human factor that has hailed to be both the greatest strength and the greatest weakness of qualitative method (Carr 1994). What is accepted in most qualitative research is to minimise obvious and avoidable sources of bias. A demonstration of this used for this research included securing some participants out of the city where the researcher is and has been employed (given her nursing history as discussed earlier in the chapter) and by taking steps to recognise the personal views of the researcher. This was achieved through openness and sensitivity to emerging concepts, continual back and forth analytic comparisons and by using reflective techniques such as memoing, supervision and note-taking.

Research paradigm

As individuals do not quickly or easily reach any sort of conclusion or resolution about their view of the nature of truth and reality, so too the researcher of this study has reflected and contemplated the meaning of the research activity they have undertaken.

Aluwihare-Samaranayake (2012) proposes that the influences of historical and cultural context shape our views of the world. To ensure a strong research design, researchers must choose a research paradigm that is congruent with their beliefs about the nature of reality (Mills, Bonner & Francis 2006).

Qualitative research broadly defined, means ‘... any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification’ (Strauss & Corbin 1998, p. 17). Where quantitative researchers seek resolve, prediction and generality of

findings, qualitative researchers seek instead insight, awareness, and extrapolation to similar situations (Hoepfl 1997). This sense of the meaning of the story within the data, sits comfortably with the researcher and in turn has guided the methodological choice for this study.

In seeking a research methodology that would provide an ontological (the subject of existence) and epistemological (the study of knowledge and knowing) fit with the researcher's position, it seemed a natural progression to explore qualitative methodologies. This led the researcher to investigate the concept of Grounded Theory and the Constant Comparative Approach of analysing data to generate theory.

Grounded Theory

Smith (2015) proposed that methodology is a set of principles and ideas that inform the design of a research study. Methods are the practical procedures used to generate and analyse the data. There are two broad methodological approaches; qualitative and quantitative. Increasingly, mixed methods research is being used. The differences between qualitative and quantitative research have been discussed and debated arguably more than any other methodological discourse in research environments (Corbin & Strauss 2015; Smith 2015; Creswell 2013; Corbetta 2003). Creswell (2013) observes both qualitative and quantitative research has a rich history derived from many disciplines and both have been employed to address almost any research topic imaginable, depending largely on what the researcher is attempting to access. Corbetta (2003, p. 2) had similar views, evidenced when he wrote '... according to whether we wish to access a world of facts or a world of meanings, we will choose one approach or the other'.

Grounded Theory is a qualitative research approach that was originally developed by Barney Glaser and Anselm Strauss in 1967 (Glaser & Strauss 1967). The self-defined purpose of Grounded Theory is to develop theory about phenomena of interest, theory which is grounded

or rooted in observation (Strauss 1987). While the methodology originated in sociology (Glaser & Strauss 1967) it has been applied to numerous disciplines since. This research, is applying it to the discipline of Nursing.

Grounded Theory methodology emerged through Glaser and Strauss' work when studying interactions between hospital staff, dying patients and their families. Glaser and Strauss, through interactive data analysis, detected a phenomenon of an unspoken taboo of discussing and confiding of feelings with regards to death and dying. This method was further used and developed by Glaser and Strauss and later extended and refined by themselves and other researchers (Glaser 1978; Charmaz 1983, Strauss & Corbin 1998).

Grounded Theory is a research methodology derived inductively through the systematic collection and simultaneous analysis of data pertaining to a phenomenon (Strauss & Corbin 1998). Strauss and Corbin clearly emphasise that the value of Grounded Theory lies in its ability not only to generate theory but also to ground that theory in data. Strauss and Corbin (1998) maintain that theories are always traceable to the data that gave rise to them.

Grounded theories can be described as fluid, because they incorporate the interface of multiple elements and because they emphasise temporality and process.

Glaser and Strauss recognised the importance of their research approach in providing tools to develop sociological theory. They considered the contemporary and popular structuralist and fundamentalist frameworks as either too abstract or not adequately developed to test the theories emerging from their research. Glaser and Strauss understood it as imperative that theory was generated from the actual data itself, in order to decrease the use of external theories that *don't exactly fit* when explaining the research phenomenon (Strauss & Corbin 1998).

Grounded Theory allows systematic and exhaustive interaction with research data, allowing meaning to be grasped from social interaction (Rintala, Paavilainen & Astedt-Kurki 2014).

Glaser and Strauss (1967) reason that this methodology could only be grounded in qualitative data in order to expose the underlying structural consequences, patterns and systems for justifying interactions. Grounded Theory is appropriate when the study of social interactions or experiences aims to explain a process, not to test or verify an existing theory (Lingard, Albert & Levinson 2008).

The ontological assumption is that reality is constructed by the participants. This philosophical stance fits with this research, as it is the participant's voice that will be privileged. These realities are what Guba and Lincoln (1994, p. 11) describe as '... multiple, intangible mental constructions, socially and experientially based, local and specific in nature ... [sic] and dependent for their form and content on the individual person or groups holding the construction'. Grounded Theory consequently, which is a general methodology for developing theory that is grounded in data, and that which is systemically gathered and continually analysed, was considered appropriate. Furthermore, Grounded Theory is an appropriate methodology for this study as there is little data relating to this issue (Rintala, Paavilainen & Astedt-Kurki 2014). In summary, Grounded Theory is developed through an intimate relationship between data collection and analysis, thus constructing theory during the research process. Simply described by Trochim (2006), Grounded Theory is a research methodology in which the theory is developed from the data, rather than the other way around.

Research methods

Ethical considerations

There are several reasons why it is important to adhere to ethical norms in research. First, norms promote the aims of research, such as knowledge, truth, and avoidance of error

(Sharma 2015). For example, prohibitions against fabricating, falsifying, or misrepresenting research data promote the truth and avoid error. Second, since research often involves a great deal of cooperation and coordination among many different people in different disciplines and institutions, ethical standards promote the values that are essential to collaborative work, such as trust, accountability, mutual respect, and fairness (Sharma 2015).

There are many ethically significant and complex issues relating to human health and research. Human Research Ethics Committees (HRECs) protect the welfare and rights of research participants. HRECs review proposals for research that involves humans, monitor the conduct of research and deal with complaints that arise from research (Sharma 2015).

Ethical clearance to undertake this research was obtained from the relevant Human Research Ethics Committee (HREC approval no. HE12/110). The HREC approval letter can be viewed in Appendix A.

Recruitment and data commenced after approval was gained from HREC. Consent was obtained from participants after they had an opportunity to read and discuss the content of the participant information sheet (PIS). The PIS can be viewed in Appendix B. Opportunity to clarify involvement and ask questions was again offered immediately prior to the interview.

The participant information sheet was written in plain English so as to ensure understanding. Participants signed a consent form prior to participating in the research and were informed that they could withdraw without prejudice. Participants nor their organisations were identified and any identifying features were coded so as to ensure confidentiality and anonymity.

Data was stored in a locked filing cabinet or a password protected computer until such time as destruction is required, which will be in accord with ethical guidelines. Data will be stored for five years after the most recent publication: as indicated in the National Statement on

Ethical Conduct in Human Research (Australian Government 2015). This will ensure integrity and respect of all participants (Australian Government 2015).

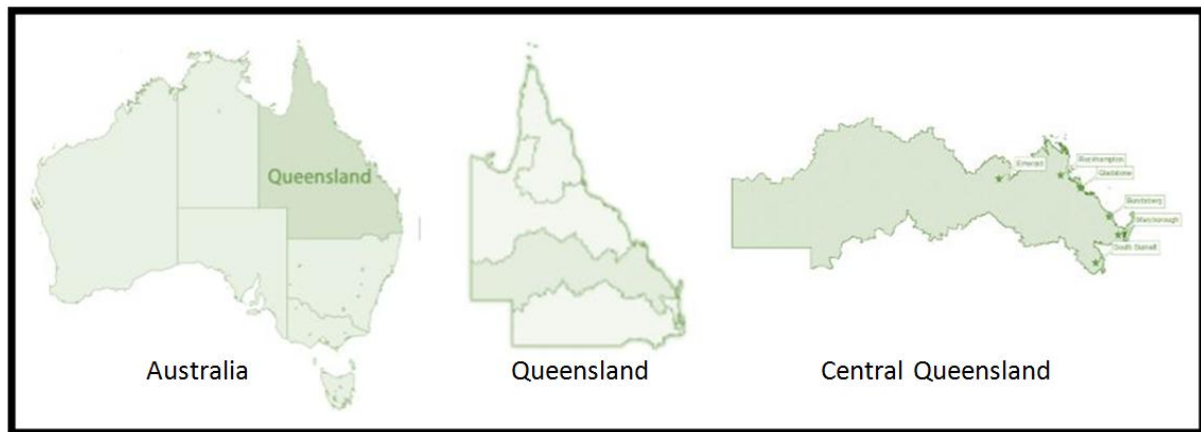
Research participants and recruitment

The realities for this particular study are those constructed by the participants; the persons in industry who make the decision to offer or decline clinical placements to universities for their BN students. The people in industry who do this are the clinical placement coordinators and may include roles such as Nurse Unit Managers, Clinical Nurse Consultants, Nurse Educators and Directors of Nursing. Participants were those people that interact closely with the University in offering placements for clinical experience. It is therefore, their realities which emanate from their own constructs of experiences that are explored. Importantly, the researcher, and those being researched are assumed to be interactively linked so that the findings are created as the investigation proceeds (Guba & Lincoln 1994). This research therefore examined the issues that influence their decisions to accept or decline BN student placement requests.

BN student placements were the specific focus of this study as it was the area the novice researcher had experience with and was the reason this research question was developed. The offering of placements for other types of nursing placements were not specifically discussed however it was acknowledged by participants that similar discourse is followed when any clinical placements are offered for nursing students.

The research was conducted in regional Queensland, Australia where the researcher first reflected on the difficulties in procuring and maintaining clinical placement positions for pre-registration nursing students. This geographical location was a deliberate strategy. A master by research project has to be manageable and cost effective. As illustrated in Table 2 below, Australia is a big country (7,692,024 km²) and indeed so is the state of Queensland (1,852,642 km²). Delimiting the geographic area made the project manageable.

Table 2: Australia, Queensland and Central Queensland.



Key stakeholders were identified and invited to participate in the research. These participants were from facilities who currently or previously had pre-registration nursing students' complete clinical placement at their organisation. A letter was then sent to persons who previously had self-identified as the individual who made the decisions to accept or decline pre-registration nursing student clinical placements.

In-depth semi-structured interviews

Interviews are among the most familiar strategies for collecting qualitative data (Merriam 2014). While all interviews are used to get to know the interviewee better (Corbin & Strauss 2015), the purpose of that knowing varies according to the research question and the disciplinary perspective of the researcher (Merriam 2014). Semi-structured interviews were conducted for this study. They are defined as a range of different forms of interviewing most commonly associated with qualitative research and are used as the means of data collection. The defining characteristic of semi structured interviews is that they have a flexible and fluid structure, unlike structured interviews, which contain a structured sequence of questions to be asked in the same way of all interviewees (McIntosh & Morse 2015).

The semi structured interview is usually organised around an interview guide. The aim is usually to ensure flexibility in how and in what sequence questions are asked, and in whether

and how particular areas might be followed up and developed with different interviewees. This is so that the interview can be shaped by the interviewee's own understandings as well as the researcher's interests (Oliver, Serovich & Mason 2005). Interviews are often the data source for a qualitative research project and are usually scheduled in advance at a designated time and location outside of everyday events. They are generally organised around a set of predetermined open-ended questions designed to guide discussion not force opinion.

Open ended questions are discussed in greater detail later within this chapter. As the interview progresses other questions emerge from the dialogue between interviewer and interviewee and information is probed. Semi-structured in-depth interviews are the most widely used interviewing format for qualitative research and can occur either with an individual or in groups (Oliver, Serovich & Mason 2005). Most commonly they are only conducted once for an individual or group and take between 30 minutes to several hours to complete. The average time of each interview for this study was approximately 60 minutes.

Sampling

As indicated above and an important consideration inherent with this research design was the use of an approach that deliberately privileges the voices of those people in positions that make the decisions in relation to accepting BN students on clinical placement within their facility. As such, a purposive sample was necessary. Purposive sampling is a deliberate selection of the type of participant to be invited who can best inform the research (Liamputtong 2013). A purposive sample is best placed to answer the research question of *What influences industry to offer clinical placements for pre-registration nursing students?*. As such, the individuals best situated to inform this research are those industry-placed people who make decisions about who gets offered a clinical placement or not and why. These participants were able to provide rich in-depth accounts and thus data that was conceptual.

According to Glaser and Strauss (1967) the number of ‘cases’ used in research to develop a theory is not crucial. Thus there is no set participant number. The social researcher does not need to know the whole field or to have all the facts from the participant group. Thus participant selection used in Grounded Theory is usually only a small number in comparison to quantitative research methods (Stern & Porr 2011).

Stern and Porr (2011) argue that there is no way of knowing beforehand the size of the sample for a Grounded Theory study. This caused the researcher in this study, who is a novice, some consternation as ethics review boards often want sample sizes. A full explanation was provided in the ethics application as to why a set number of participants could not be pre-determined. In Grounded Theory, the sample size is considered appropriate when data saturation occurs (Liamputtong 2009). Data saturation is known to occur when no new data emerges, that is, when the same patterns keep emerging in the data, indicating that data saturation has been achieved. Saturation was achieved in this research at nine participants.

Collecting the data

Contact with participants was through email or telephone to identify a suitable time to conduct the interviews. Data was collected through semi structured individual interviews by the researcher at a time and place that was convenient to the participant. Consent was obtained through the consent document and then again confirmed verbally, immediately prior to commencement of the interviews. Each participant was interviewed once, with the ability to return and clarify if either party have any information to add. This was not undertaken and the interviews remained as a single entity for each participant, as clarity was found within the original interviews.

The approach of the researcher included genuine interest, a non-judgemental attitude and assured participant confidentiality, this facilitated open and honest discussion. Interviews

were, with the permission of the participant, taped. Taping the interview allowed the researcher the ability to be fully attentive to the participant (Smith 2015), it reduced distractions that would have been present should the interviewer have to write the answers to the questions at the time of the interview.

The interviews were transcribed verbatim to ensure that the integrity of the conversation was maintained (Oliver, Serovich & Mason 2005). Both supervisors individually and independently examined the transcripts for credibility. It is important to the researcher to have as much information from the interview transcription as can be provided, giving context to what transpired during the interview.

The transcription enabled the interviewer to successfully analyse the data through the use of Grounded Theory data analytical methods, prior to conducting the next interview. This constant comparative method of data analysis will be discussed in detail in the data analysis section of the chapter. Reflective notes and memos were kept whilst listening to and reading and re-reading the transcribed interviews. These notes and memos were included during the analysis of the data. Glaser (1978) believes memos encourage analysis that is grounded in the data because the researcher must consider how the properties of the information obtained relates to each other whilst providing evidence of this from the raw data. This is especially important in the audit trail of Grounded Theory. It is important with regard to identifying your own bias and remaining objective. Notes and memos are also important to record any contextual issues that occurred during the interview, that is; where it was located, external noise and phone interruptions.

Questions used to collect the data

Open ended interview questions are typically used when the same questions are asked of all interviewees. Open-ended questions are ones that require more than one word answers (Adler & Rodman 2006). The participants can answer the questions however they choose to respond.

Open-ended questions are helpful in finding out more about a person or a situation. There are no yes or no or right or wrong answers.

The ability to ask open-ended questions is very important. A well-structured, open-ended question is designed to encourage a full, meaningful answer using the participant's own knowledge and/or feelings, tending to be more objective and less leading than closed questions (Wasik & Hindman 2013). In-depth responses are therefore expected, along with a description or explanation (Alder & Rodman 2006). This was important for this research as rich, in-depth descriptions were required.

The interview prompt sheet the researcher developed consisted firstly of a determining question. This was a deliberate strategy to affirm that the participant was the correct person within their facility to enable a response to the research question. Unlike the open ended questions, this determining question was purposeful and closed. The question was *Are you the person at your health care facility, who determines if BN students are offered clinical placement following a request from an education provider?.*

Once affirmation was provided by the participant that they were in fact, the person who made the decisions with regards to the research question *What influences industry to offer clinical placements to pre-registration nursing students?*, the following four open-ended questions were asked, with probing occurring according to the responses given:

Question 1

Please tell me about the most influential factor that enables you to offer clinical placements for pre-registration nursing students? (Probing occurred according to response)

Question 2

I am interested in hearing your thoughts about the factors which might restrict you from offering clinical placements for pre-registration nursing students? (Probing occurred according to response)

Question 3

What do you consider influences your decision making process when offering clinical placements for pre-registration nursing students? (Probing occurred according to response)

Question 4

What would enable you to offer more clinical placement positions for pre-registration nursing students? (Probing occurred according to response)

Data analysis

The above questions and subsequent responses to probing questions elicited a lot of data. All of which required in-depth analysis. Analysis of data within a Grounded Theory approach is a complex iterative process (Orton 1997) with a continuous interplay between data collection and data analysis (Urquhart et al. 2010). This occurs as a result of the researcher continuing to gather data and core theoretical concepts emerging (Pandit 1996). Early linkages are thus developed between the theoretical core concepts and the data. This embryonic phase of the research tended to be very open and took this novice researcher months to complete. It was though, fulfilling to have undertaken it and the researcher learned a lot.

Figure 6 illustrates the constant comparative method of data analysis within a Grounded Theory approach. It demonstrates the process from the initial decision of the researcher to follow a qualitative paradigm right through to the generation of a ‘Grounded Theory—rather, a theory grounded in the data. Strauss and Corbin (1998) state that through this method of data analysis, the concepts and the relationships among them are not only generated, but are also provisionally tested.

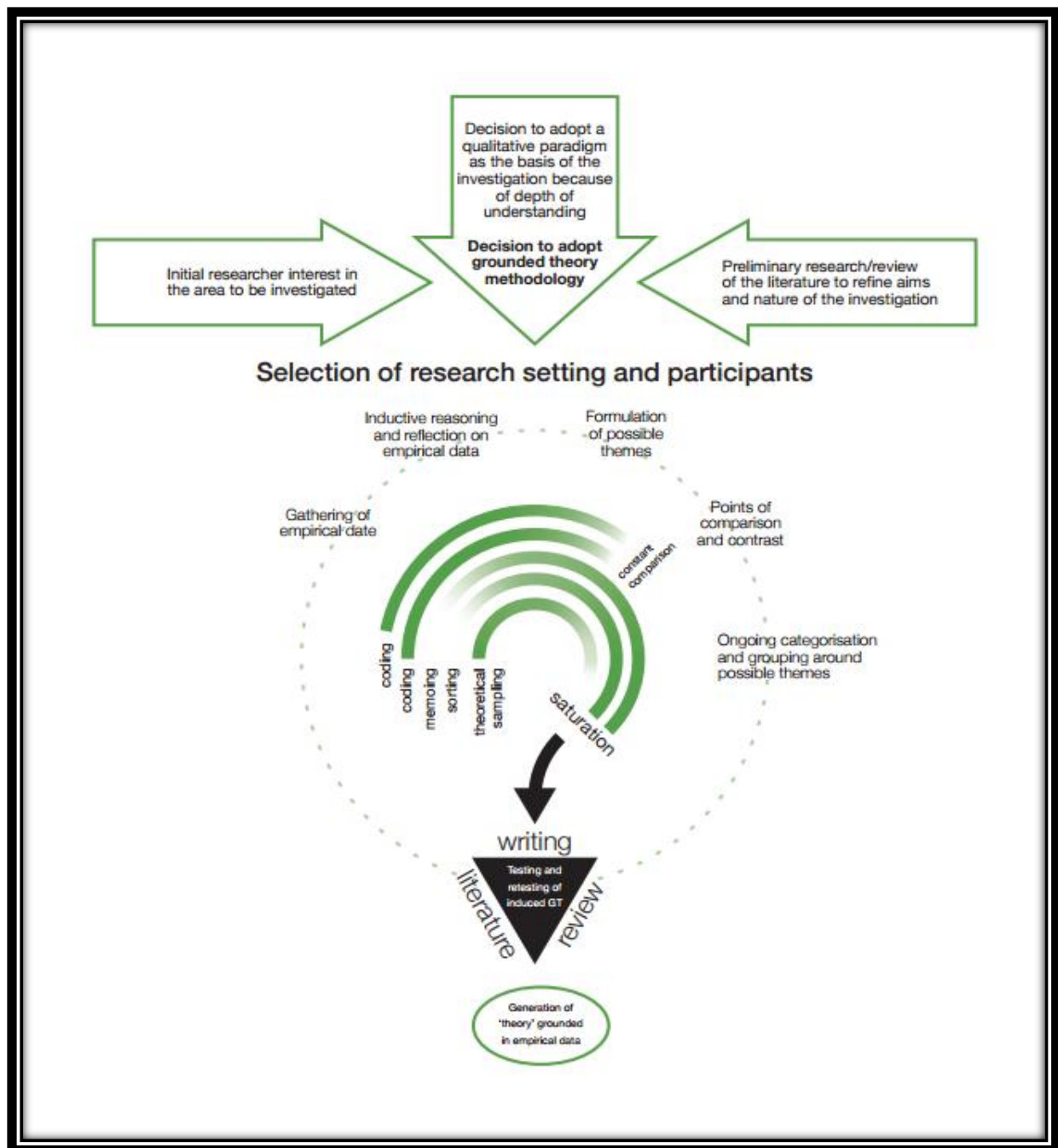


Figure 6: The Grounded Theory approach.

(adapted from Fisher 2010)

Coding

Coding in Grounded Theory is the process of analysing the data. The approach taken for this research is a coding technique that divides the process into three phases which are labelled open, axial, and selective. Strauss and Corbin (1998) insist on the use of the constant

comparative method within these phases, with each having specific procedures aimed at achieving distinct purposes. Although Strauss and Corbin (1998) have admitted that the lines between the three phases are somewhat artificial and that open, axial, and selective coding might even be carried out concurrently, they assert that each phase requires different interventions on the part of the researcher. At first, their coding process appears simple; however, as one moves deeper into their methods, the procedures the researcher must use become increasingly more complex and detailed (Walker, Henderson, Cooke & Creedy 2011).

Figure 7 illustrates that there are three stages involved in the coding process which will now be explained.

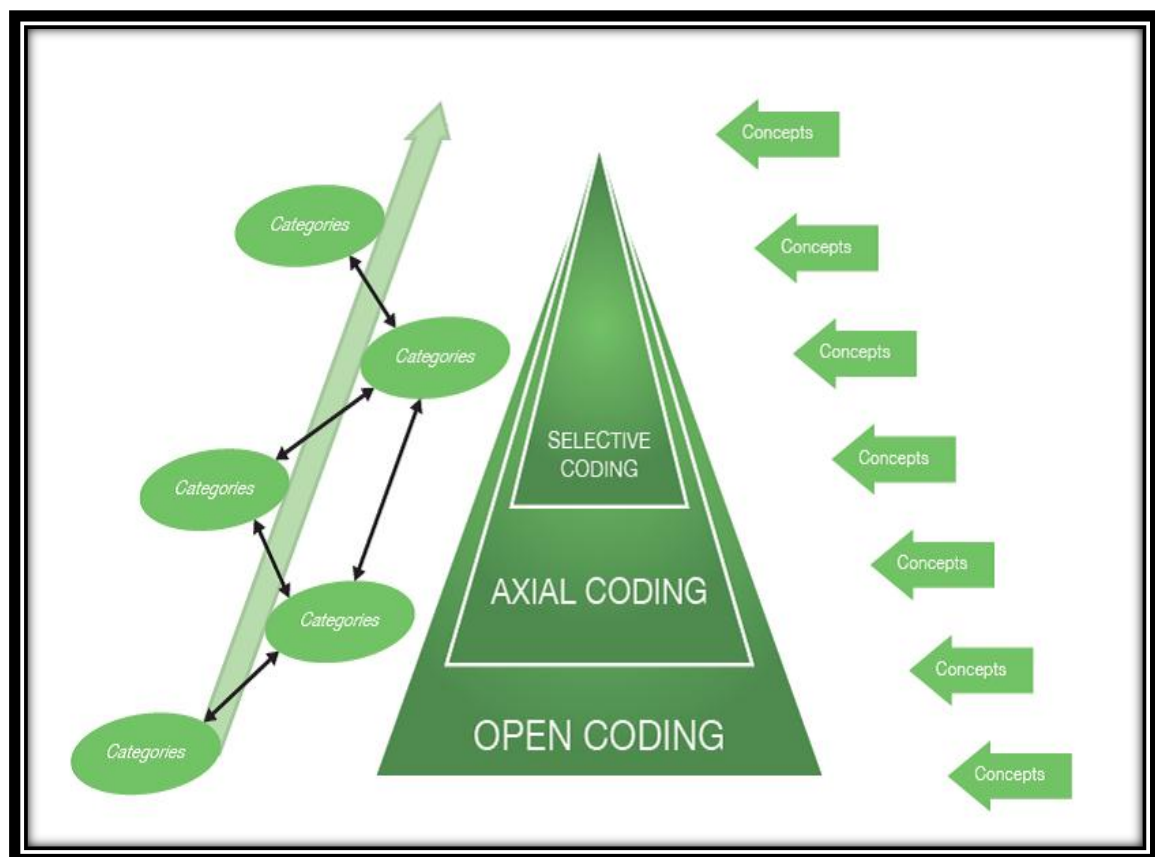


Figure 7: The three stages involved in coding.

(adapted from Fisher 2010)

Open coding is the first stage of grounded theory analysis (Glaser & Strauss 1967; Strauss & Corbin 1998). Open coding allows the text of the transcripts to be transparent to the researcher and then thoughts, ideas and meanings contained within the text to be exposed (Strauss & Corbin 1998). Categories are then developed. Open coding began after the first interview was transcribed and continued with consecutive interview transcripts, until no further categories could be identified and saturation of categories was achieved.

Initially the transcripts were read line by line to begin the process of conceptualization of the data into meaningful units (Strauss & Corbin 1998) and interactions considered as significant in the data were then given a concept label (Corbin 1986; Glaser 1978; Strauss & Corbin 1998). The purpose of labelling, as supported by Strauss and Corbin (1998) was to facilitate the grouping of concepts in the data. The meaning of the concept also reflected the context of what was being said (Strauss & Corbin 1998).

Ultimately through constant comparison, early categories were defined from the concept labels and were grouped like for like and given a name with consideration being made toward their properties and dimension. Memos and diagrams added meaning to the categories and served as a prompt for questioning aspects of previously identified phenomena with the consecutive data collection. However, at this open coding stage, categories and subcategories were not fixed, meaning that they could change with further analysis. Whilst many categories were identified at this stage, further analysis at the axial coding stage would reveal that some represented conditions, some actions/interactions while others were consequences to the central phenomena (Reid-Searl 2008, p. 55).

The goal with axial coding is to systematically develop and relate categories and subcategories along the lines of their properties and dimensions (Strauss & Corbin 1998).

Ultimately this forms what Strauss and Corbin (1998) describe as more complete

explanations about the phenomenon. To achieve this, the data that was fractured during the open coding stage was required to be reassembled through constant comparative analysis (Strauss & Corbin 1998). Connections among categories become evident as the process progresses.

However, these initial thoughts of how concepts related, even though they were derived from the data, needed validating and further elaboration through continued comparison of data from incident to incident (Strauss & Corbin 1998). The reason for validation, according to Strauss and Corbin (1998), is that these initial relational statements are abstractions, meaning that they were developed at a conceptual level from the coding paradigm and not immediately from the raw data level (being the interview transcripts).

Selective Coding was then undertaken which is 'the process of integrating and refining the theory' (Strauss 1998, p. 143). This is stage three and according to Strauss and Corbin (1998) this is when refinement of the developed concepts takes place and a core category or major theme emerges. This is an integrative step where all of the other categories become subcategories of this core category. Choosing the central category from all the multiple categories that existed required the researcher to, yet again, go back to the data but this time using criteria established by Strauss and Corbin (1998). These criteria included sorting which category was the focus and then making sure that all other categories related to this central category. Additionally, the central category needed to appear frequently in the data and it had to provide a logical and consistent explanation (which had evolved by relating other categories). Finally, the central category had to explain variation as well as the main point made by the data (Strauss & Corbin 1998).

Once the central category was confirmed, the next step was to explain the central explanatory concept. This meant further analysis of the data and again asking questions such as those adapted from Glaser and Strauss (1967). These included:

- what is going on in the data?
- what is the focus of the study and the participant's relationship with the data?
- what is it that continually appears in the transcripts?
- what is the basic social issue or problem that is being dealt with by the participants?
- what processes are helping participants cope with the issue/problem?
- what comes through that might not be directly said?

Several strategies were then employed to facilitate the integration and refinement of the central category and related sub categories around the central explanatory concept (Strauss & Corbin 1998). Strategies included writing a story board that integrated the relational statements (which had been developed at the axial coding stage) to the central explanatory concept. Extensive diagramming and concept mapping also occurred to facilitate the integration of categories to the central explanatory concept. All diagrams that had been developed during the open and axial coding stages were revisited which allowed the researcher to see not only the refinement of the categories and the central explanatory concept but also to see the progressive development of what would become the larger theoretical scheme. Once the central explanatory concept had been integrated and grounded, categories were again revisited. This necessitated the researcher returning to the transcripts to ensure that nothing was missed in the data, meaning that what was said by participants was reflected in the central explanatory concept. Upon confirmation, the central explanatory concept then became the larger theoretical scheme representing the substantive theory.

Confirming that no further data needed to be collected was an important step to ensure that theoretical saturation had occurred. Theoretical saturation is a point where additional analysis

no longer contributes to new discoveries about the data (Glaser & Strauss 1967; Strauss 1987) meaning no new properties, dimensions, conditions, action/ interactions or consequences are present in the data. Strauss and Corbin (1998) suggest that saturation is more a matter of arriving at a point in the study where collecting any further data is counterproductive and the 'new' that is uncovered does not add to the study.

Integration of the findings with the literature helped identify theoretical grounding that could further explain what had been discovered. Using the literature in this way meant it could be used to support or negate the findings or confirm where the literature differed, was over simplistic or where it had explained the phenomena only partially (Strauss & Corbin 1998). Thus, bringing the literature into the writing meant allowing for the extension, validation and refining of knowledge that existed in this field of study (Strauss & Corbin 1998). Finally, with confirmation from the literature the larger theoretical scheme would take the form of the substantive theory as discussed further in this thesis. Although the research process of data collection and analysis has been discussed, none of this progressed without the researcher ensuring that the process was trustworthy. The next section of this chapter will consider how trustworthiness was achieved in terms of credibility, auditability and transferability.

Over time the researcher becomes increasingly engaged in verification and summary of the concepts, and as it progresses, distinction tends to evolve toward one core category that is central. Thus a theory, grounded in the data is built, one that is faithful to and illuminates the area under study (Strauss & Corbin 1998).

Memos and diagrams

Groenewald (2004) asserts that memoing is an important and useful data tool. It is the act of recording reflective notes about what the researcher is thinking and feeling from the data.

Memos are notes by the researcher to themselves about some idea or thoughts regarding a category or property and especially about relationships between categories. These memos add

to the credibility and trustworthiness of qualitative research (Groenewald 2004) and provide a record of the meanings derived from the data. There are no rules pertaining to memoing. However, each memo ought contain one idea and must be dated and referenced (Groenewald 2004). When doing research, some kind of method is needed to overcome the natural tendency to forget particulars and nuances, as recalling details are an extremely important aspect of finding meaning in the data. Memoing is one such method.

Memoing was undertaken throughout the data collection and analysis phase, with reflection continuing right up to the point of thesis submission. Thoughts and ideas still emerged as this researcher wrote the actual thesis. Inevitably they had to cease, but they were an ongoing means of reflection throughout this researchers learning journey. Through the researcher's memoing, emergent theories were indicated early, as categories became obvious as comparisons were reflected on. Concept drawing and linkages through diagrams helped the researcher link connections and make comparisons from the information emerging from the data. An example of this is provided in Appendix C.

Glaser and Holton (2004, p. 12) write:

... memos help the analyst to raise the data to a conceptual level and develop the properties of each category that begin to define them operationally. Memos present hypotheses about connections between categories and/or their properties and begin to integrate these connections with clusters of other categories to generate the theory. Memos also begin to locate the emerging theory with other theories with potentially more or less relevance.

Theoretical sensitivity

Without theoretical sensitivity, Glaser and Holton (2004, para. 43) believe '... to preconceive a theoretical outline is to risk logical elaboration'. They further state the essence of theoretical sensitivity is produced by the ability to generate concepts from data and to relate them according to normal models of theory in general (Glaser & Holton 2004). Generating a

theory from data means that most ideas and concepts not only come from the data, but are systematically worked out in relation to the data during the course of the research (Glaser & Strauss 2012).

Glaser and Holton (2004, para. 43) insist the ‘first step in gaining theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible’. Glaser and Holton (2004) maintain a researcher mandates vital characteristics for the development of theoretical sensitivity. They include personal and temperamental traits that enable the researcher to maintain analytic distance, endure confusion and regression, all the while remaining open, trusting to preconscious processing and to conceptual emergence. In addition to the above mentioned traits, researchers also require the ability to develop theoretical insight into the area of research and the ability to make something of these insights. These qualities, combined with the capacity to conceptualise, organise, make abstract connections, visualise and think in multi layers, all combine to establish theoretical sensitivity.

Theoretical saturation

Theoretical saturation has been defined by Sandelowski (2008) as the endpoint of theoretical sampling and is achieved via constant comparison analysis. The signature sampling and analysis strategy in Grounded Theory inquiry. Theoretical saturation signals the point in Grounded Theory studies at which theorising the events under investigation is considered to have come to a sufficiently comprehensive end. At this point, researchers are comfortable that the properties and dimensions of the concepts and conceptual relationships selected to render the target event are fully described and that they have captured its complexity and variation (Sandelowski 2008).

Strauss and Corbin (1998, p. 188) state ‘... the general rule when building theory is to gather data until each category is saturated’. This means until no new or relevant data seem to emerge regarding a category, the category is well developed in terms of its properties and

dimensions demonstrating variation and the relationships among categories are well established and validated. Theoretical saturation is of great importance. Unless a researcher gathers data until all categories are saturated, the theory will be unevenly developed and lacking density and precision (Urquhart 2001).

Although data saturation was identified after nine interviews, theoretical saturation was not concluded until full analysis of the categories that had emerged from the data had occurred. This took time and was a *dense* project, whereby, in finalisation the theory that emerged, grounded in the data, is discussed in the findings chapter.

Trustworthiness in data analysis

Qualitative researchers need to demonstrate that their studies are credible (Creswell & Miller 2000). Challenges regarding validating or demonstrating rigour in the qualitative paradigm continue to be raised from the quantitative community (Tobin & Begley 2004). Rigour is the means by which we demonstrate integrity and competence, a way of demonstrating the legitimacy of the research process. Without rigour, Tobin and Begley (2004) believe there is a danger that research may become fictional journalism. The attributes of rigour span all research approaches. It is the construction and operationalisation of these attributes that require innovation, and transparency in a qualitative study, such as the processes used in this research that was outlined above.

The introduction of Lincoln and Guba's (2013) ideas on trustworthiness provided an opportunity for qualitative researchers to explore new ways of expressing validity or rigour. As such, trustworthiness is the nomenclature used in this research, to describe what might be otherwise termed as rigour. The concept of trustworthiness was paramount in the conduct of this study during analysis, memoing and theory development. Trustworthiness can be demonstrated through credibility, transferability, dependability, and confirmability (Lincoln & Guba 2013).

Credibility addresses the issue of 'fit' between participant's views and the researcher's representation of them (Schwandt 2001). It poses the questions of whether the explanation fits the description (Janesick 2001) and whether the description is credible. Transferability refers to the generalisability of inquiry. It relates to how the participants fit with the realities described. This will be evidenced throughout the study with excerpts from transcripts, quoting the voices of the participants to assist the reader to understand the context of the discussion undertaken.

Dependability (comparable with reliability) is achieved through a process of auditing. Researchers are responsible for ensuring that the process of inquiry is logical, traceable and clearly documented (Schwandt 2001). The direction and suggestions from the researcher's supervisors have assisted in ensuring dependability. Reflexivity is also central to the audit trail, in which researchers keep a self-critical account of the research process, this is evident in notetaking, memoing and diagramming. All of which were undertaken during the conduct of this research. Confirmability is concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination, but that they are clearly derived from the data (Tobin & Begley 2004). Through openness and sensitivity to emerging concepts, a continual iterative process of analytic comparisons (particularly during axial coding) and constant modifications and confirmations, confirmability was assured. It was indeed a complex process, nonetheless the researcher learned a great deal from the exercise.

This chapter presented Grounded Theory methodology and the methods used to collect and analyse data to identify *What influences industry to offer clinical placements for pre-registration nursing students?*. The chapter began by acknowledging the researcher's prior knowledge and relationship with the research, and explained why the researcher chose a qualitative paradigm to undertake the study.

Further explanation pertaining to the adoption of Grounded Theory methodology, with consideration given to a Strauss and Corbin (1998) approach to the research design was included in the chapter. Participant recruitment and selection, interview strategies and data collection were discussed, prior to exploring the method of data analysis that was utilised. Data analysis and the systematic processes of open, axial and selective coding was thoroughly described. Definitions of theoretical sensitivity and theoretical saturation were given with examples to illustrate their application in the research design of this project. Considerations to rigour in data analysis, specifically trustworthiness was provided as was its relationship to this study. Chapter four will discuss the results of the Grounded Theory study.

CHAPTER FOUR

Research findings

This chapter provides the results of this research project which sought to examine *What influences industry to offer clinical placements for pre-registration nursing students?*. As per the Grounded Theory approach to data analysis which utilised the constant comparative method, as elucidated in chapter three, core concepts and the central category will be discussed. The chapter commences with an explanation of the core concepts derived from the data and an explanation of the central category the **Strength of the Relationship**. The central category has three core categories which are:

- Communicating,
- Valuing and
- Supporting.

These categories will be explored within the chapter. Further to this, major elements that serve to inform the three core categories are also discussed. Summation of key points will conclude the chapter.

Overview

Findings that emerged from the data collected from the nine participants were sorted and coded into categories as they became apparent. As previously described this occurred as a result of constant comparative analysing. This systematised and comprehensive approach lead to the emergence of a central category; the **Strength of the Relationship**. This central category is informed by three core categories: Communicating, Valuing and Supporting.

Central category – *Strength of the Relationship*

The emergence of the central category as a result of the iterative data analysis process resulted in the development of the substantive theory, namely '**Relational Strength**'. This theory asserts that the primary influence when offering clinical placement for pre-registration

nursing students is the **Strength of the Relationship** between the universities and CPP.

Findings suggest that Universities need to have a strong relationship with their industry partners, the CPPs, to ensure clinical placements continue to be offered to them.

The data revealed that it is the **Strength of the Relationship**, developed through effective communication, and by valuing and supporting each other, that meaningful partnerships can be developed. In turn, hurdles or challenges can be overcome, miscommunications can be set right and positive interactions will be those which are remembered before negative ones.

Participant 9 (P9) illustrates this as they explained the impact that a poor relationship could have on clinical placement offerings, and why the need for a strong partnership is paramount:

It does need to be a good relationship because if it becomes a burden to us that we are then managing issues then it becomes a less desirable—so if I've got a troublesome student that's—we're putting a lot of resources into managing and we're not getting any support from the University, then that becomes a negative impact on us ... and that will then influence us in the future because you're more reluctant to go back down that path so it's about the University supporting (industry)—so it's that mutual respect, mutual understanding of each other and that it has to be a partnership. P9

As previously stated, three core categories that influence the relationship became apparent.

They are Communicating, Valuing and Supporting. The core categories are integral to the relationship, and as presented in Figure 8, harmony within the core categories results in equilibrium within the relationship, fostering strength.

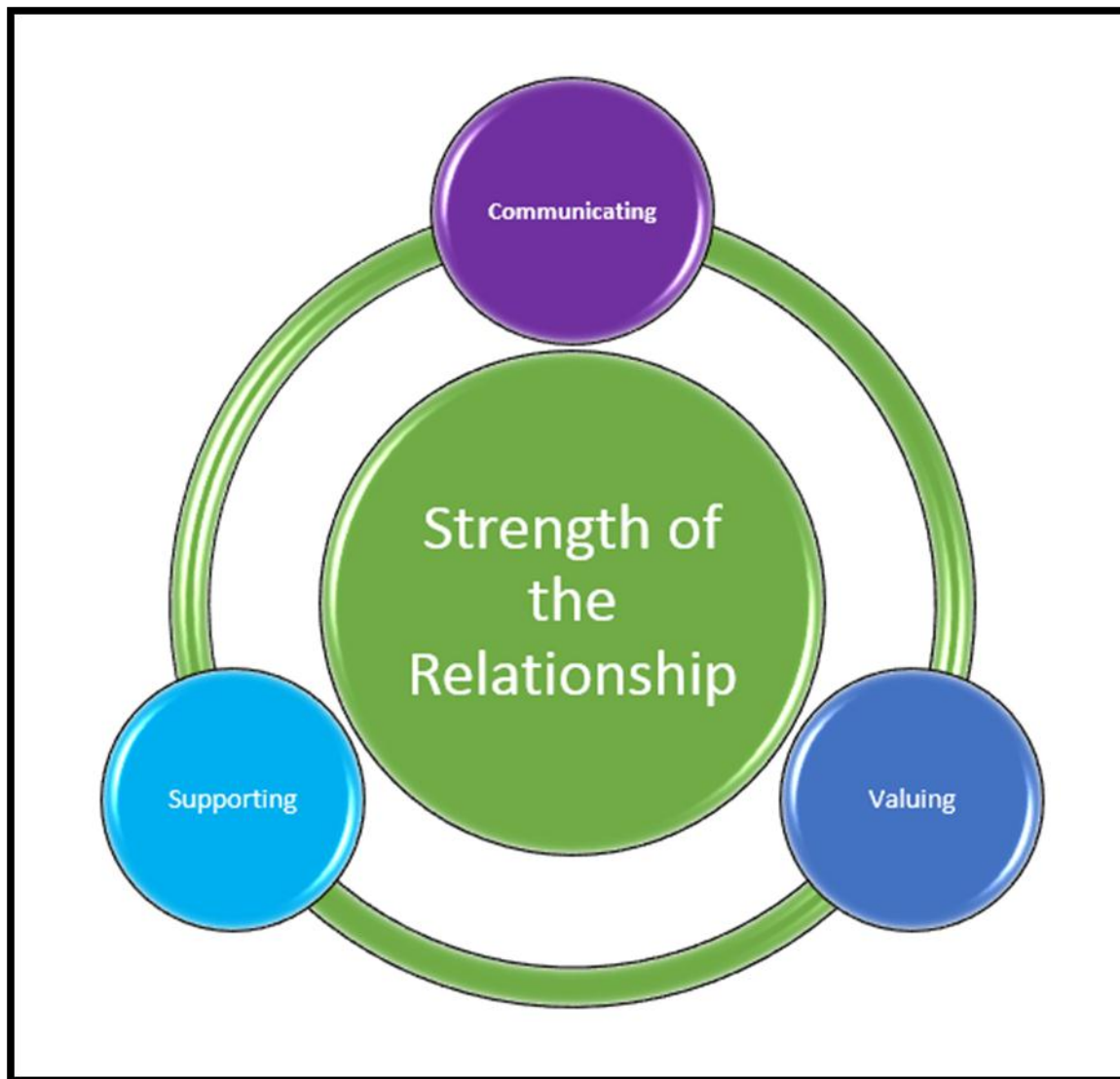


Figure 8: Strength of the Relationship, the central category, influenced by three core categories: Communicating, Valuing and Supporting.

Elements of these core categories which include collaborating and negotiating, understanding and knowing, attitude and willingness, burden, workload and skill mix, and staffing and supervision are paramount to the maintenance of strong and positive relationship between the Universities and Clinical Placement Providers (CPP). To enhance a strong relationship, participants indicated that there must be quality communication between the two parties, ensuring the fostering of a culture that values the other and works collaboratively to provide support.

Health Workforce Australia (HWA) (2012) in their report 'Promoting Quality in Clinical Placements' identify a culture of quality within the clinical placement environment as a critical element to enhancing clinical placement experience. HWA go on to describe how such a culture values positive relationships, supports learning, and promotes best-practice in education and service delivery (HWA 2012, p. 5). It is the development and maintenance of positive relationships that enhances a clinical placement partnership in order to service pre-registration students. Participant 7 describes how having a relationship influences them to offer clinical placements.

We prioritise the facilities, the University facilities in our local area, and then we take on students from facilities where we've established (these relationships)—we have a relationship with the nursing education providers. P7

Participant 6 proclaimed the relationship they had developed with their local education provider as one of importance to their organisation:

(The relationship with the uni) it's very important because we don't just have the students coming through ... I also encourage our staff for professional development. So we've had actually PC's (Patient carers) who are now going to study registered nursing so having that good relationship is important [sic] ... the fact that we have a relationship with the University—we're promoting that. P6

Participant 5 expressed a positive view on having developed a relationship with a specific University contact person with whom they collaborate and communicate when planning clinical placements within the facility:

The University here has a good reputation and I think (name) does work really very well and does a great job [sic] ... yes, we work very well together, we have a really good working relationship I believe. P5

Participant 5 also indicated that they believed when the relationship between both the Universities and the CPP is strong, mutual benefits occur. These reward both industry and universities and ultimately pre-registration nursing students.

I'd like to say relationship, the relationship that the mid-tier local has with the practices. The model that we've got here works really well, so you've got (industry) supporting the University, supporting general practice. P5

The above data supports the notion that it is the promotion and preservation of affirmative relationships that enrich clinical placement partnerships in order to benefit pre-registration students. The following core categories and informing elements will now be explicated using the voices of the participants to illustrate the findings.

Communicating

All participants indicated that communication and collaboration between the Universities and the CPP is of prime importance. Communicating effectively was thought to ensure that valuable learning opportunities in the form of clinical placements are provided to pre-registration nursing students.



Figure 9: The Core-category communicating and associated elements.

Participants indicated that Universities need to work more closely with health services in order to operationalise clinical placement opportunities for students. Forging collaborative partnerships between the Universities and the CPP through mutual visioning and understanding of each other's primary business and goals, was considered the key to establishing a good working relationship. The following participant demonstrates this when they spoke of the early development of the long standing relationship between their facility and the local University:

The relationship between the facility and [University] seems to be a fairly strong factor ... it's long standing. And right from the start when the University became

involved with student placements I think initially those introductions and those meetings were really vital in establishing good practices going forward. P7

Participant 7 further impresses that having a well-developed relationship allows for a better understanding of each other's needs. This is considered important when it comes to offering clinical placement opportunities:

We've developed good relationship with [University] staff, Bachelor of Nursing staff and that helps us formulate numbers, provide clinical areas that are going to provide the students to fulfil their clinical needs, according to the subject matter of those clinical terms (semesters). P7

The process of clinical placement relies upon clear and effective communication between the Universities and the CPP. Given that each organisation has its own goals and agendas, as well as the common goal to deliver clinical education, communicating effectively is paramount. Participants identified the importance of liaising closely, having ongoing discussions with the University and approachability as influencing effective communication. Participant 3 clearly felt their organisation needed to feel familiar in their dealings with the University, so that they have a type of relationship that allows easy and timely contact:

So, if I was to surmise [conclude what was particularly important to the relationship] that would be obviously communication and approachability would be high on the list of what you would need from the University. P3

Some organisations use a 'model' of communication whereby they have a delegated person who negotiates between the parties. Participant 5 explains how this facilitates a mutually acceptable clinical placement process that meets the needs of industry and of the education provider:

... it would be up to me to try and liaise with the (University and [general practitioner] (GP)) practices to see who will take those students ... I'm there to broker almost between the two and to make sure their learning needs are met in a safe way and I think that makes a very big difference. P5

Collaboration in health care is considered important as 'health care professionals assume complementary roles and cooperatively work together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans' (O'Daniel & Rosenstein 2008, p. 271). By maintaining strong communication and a collaborative approach between

the CPP and Universities, participants felt such a joint effort would ensure students' needs could be met during placement.

Participants described that when collaborations were not overt both parties experienced difficulties in planning, implementing and evaluating clinical placements for pre-registration students. Participant 3 spoke of a situation where they were unable to easily reach the education provider despite the fact she was hosting a student on clinical placement:

With regards to the University I don't know the person who was facilitating last time, communicated with the staff very much, so they don't see them as someone they can approach or [get support from]. P3

A collaborative approach was also considered important by Participant 2 who reflected on the need for the two institutions to work closely together:

... you need to have the University work as a partnership, so obviously you make sure you've got really good ties in those areas. P2

Collaborations, sometimes referred to by participants as clinical partnerships were seen as essential in order to effectively immerse students into the clinical systems. A collaborative approach promotes an understanding that can contribute to quality improvement, teamwork, 'just' culture and critical thinking for the pre-registration student (Didion, Kozy, Koffel & Oneail 2013). Participant 5 maintained that when working in collaboration with the respective University, student nurses get a better experience and develop a deeper understanding of nursing practice. This heightened awareness includes an appreciation of professional expectations, cultural norms and the everyday business:

... to ensure that the student knows the parameters, is there on time, wears the proper uniform, knows the code of conduct of behaviour, writes up the clinical book, gets the full reports. P5

Participants highlighted the benefits that were derived when the 'University' took the time to 'truly know' the organisation, the philosophy and the everyday business of the facility to which students were being placed. By knowing, appreciating and understanding the CPP participants described how requests for certain clinical placement dates, particular wards,

student numbers and the like, would be more informed. Armed with this understanding, Universities would appreciate the constraints of Clinical Placement Providers as much as needing to fulfil the needs of the University. Participant 1 (P1) spoke of a University knowing their facility more intimately and how mutual understanding can lead to compromise. They commented:

liaising with the universities to come to a compromise on what the universities need and what our services can offer ... it's the universities understanding, what community nursing and residential nursing—what's the word—the model of care that we deliver. P1

Issues that participants identified when Universities didn't take the time to get to know the CPP included, inappropriate dates requested for student placements, last minute cancellations that impact on CPP planned staffing and requests being so far in advance that the CPP could not possibly plan. Further to this, other issues included requests that were contradictory or that were too late in the year making the clinical calendar full with CPP business. Participants stressed the importance of the Universities getting to know the CPP in terms of who their stakeholders are, what their model(s) of care is, the size and capacity of the facility, and what resources were available, human and operational. Participant 2 describes how operational issues and parameters such as Christmas holiday period, can effect decisions to offer clinical placements:

Patient numbers, because we actually shrink down across that time frame, usually two wards mesh together, so that you can achieve maintenance on whichever that empty ward is, and for this year, it actually didn't open again until towards the end of January. So that's what I think is going to be an issue for a student, because that's fine to have them, but for a start they might be thinking they're going to a surgical ward yet our surgical ward at Christmas time last year was full of medical patients. P2

Participant 5 also discusses this issue and alludes to how mutual understanding, specifically of what type of supervision the parties can agree to for the nursing students, could benefit both parties:

... that understanding of what each particular partner or practice requires as supervision model. Because it is a tough thing being an RN on the ward and then being given [a student]. P5

It was not only participants from acute care settings that identified these issues. Participants from aged care facilities expressed similar sentiments regarding a lack of understanding by Universities of logistics related to the aged care sector. These participants described how unskilled workers were already having to be supervised by limited numbers of registered staff. As a result of the limited numbers of RNs, who are also required to supervise BN students, when they are approached by a University with an unrealistic request for clinical placement, often say no. Such requests were interpreted as the education provider not knowing or caring about the restraints already experienced in that particular sector. When asked about barriers to offering clinical placements the following participant stated:

They don't have an RN working fulltime, so that's always taken into consideration with the type of clinical placement they can do. P2

Universities understanding how age care and community nursing works and the fact that we can't do fulltime blocks all the time, rostered work is better for us rather than having students, a number of students in for two full week blocks. P1

If the University was collaborative, as demonstrated by a strong understanding and knowledge of the facility, participants indicated that placement issues could be overcome. Participant 2 identified how extra *student clinical placements* can sometimes be accommodated as a result:

... because they know our facility, they know our values, they know our interactions. We've been lucky in the past because a lot of times it's been staff that know this organisation, who have previously worked here. P2

Valuing

The ways in which organisations, clinical staff and students themselves, placed value on the clinical experience was shown to be an influence when CPP offer clinical placements for pre-registration nursing student. Thus valuing could be demonstrated as positive (people valued the experience) or, it was not valued (a negative experience). Participants used words and phrases such as; *it's an expectation*, *passionate about students*, *important part of*

organisation, burden to staff and *it's stressful*; to describe their interaction with pre-registration students in their facility during clinical placement.



Figure 10: The Core-category Valuing and associated elements.

Participant 9 shared how their organisation has come to recognise they want to be involved in the development of the nursing profession. They feel they do this by encouraging student involvement and education through clinical placement:

We have a passion and we want to see a finished product that is a professional registered nurse. In the past that hasn't always been what the finished product has been. P9

Participant 1 also voiced that within their organisation some RNs had a passion for working with student nurses. This passion was encouraged by providing training for interested staff:

So there's definitely what I would call champions out there who thoroughly enjoy having students and are looking to improve their own skills and push that through to undergrad students and so we've done training to match those requests. P1

Participant 3 described that when the staff are keen to have the students on clinical placement it encourages student involvement and engagement:

And the majority I believe at the moment of staff are very keen to have students in. Certainly we have other students coming from registered training organisations as well and they've been well accepted this year and certainly utilised well within the work area. P3

Participant 7 acknowledged that students contributed *another dimension* by enabling those staff actively involved with them to feel valued and an important part of the students' clinical journey:

Yes, the other thing is, a big influential factor in students wanting to come to (facility name) ... I think in the past is that we've got staff that really—that want to teach, that want to be mentors to these students and that is a big plus for us ... it makes our staff feel valued too because they feel that they've got something to offer. P7

Participant 4 identified that there was a perception within her organisation that certain nurses had a natural ability to interact with students:

There are certain nurses that really love teaching and love having students here and same with practices ... So they just have that sort of teaching philosophy. P4

A teaching *interest* as identified above did not appear to resonate with all staff who are asked or delegated the responsibility of mentoring during student nurse clinical placement. This is illustrated by Participant 6 who disclosed:

Look you try your best to pick your best staff to work with people, but you sometimes get a personality clash so having a facilitator who might know their students quite well to sit down and work out okay who best—what's the best fit with them. P6

Participant 2 also spoke about staff who are given the responsibility of student supervision, but who could see no value in the exercise, and how they would prefer to match students with staff that want to work with them:

... and also to I suppose, not what was unspoken just but I know it to be the case, that you want to be able to pick the people that the students can be with because you know that if you put them with the wrong person, we'll experience problems like we have done in the past ... we're not always successful with that because often as you know, you've got people that you've got in your organisation so the only way that you can try and fix that is—well not fix it I suppose, but to not accept it. P2

Participant 3 spoke of similar situations:

In the past there's been issues with students and I know that students have had issues with some of our staff that has been brought to our attention in the past. I think most of those people that had a negative attitude towards students being there have since left. We are trying to wean those people out of the organisation because it's not only students they're negative about, it's pretty much everything. P3

Participant 5 touched on the concept that staff may not like to supervise students due to the perceived threatening nature of the experience. Confidence, or lack-there-of, was considered to be a contributing factor:

Another one is the nurses just don't want to do it, they don't feel confident or they feel threatened, they just don't want to do it. P5

Participant 2 iterated many times throughout the interview that at their private acute hospital, it was the expectation that clinical placements would be provided for the local universities pre-registration nursing students:

It is an expectation, it's not a question of whether we do or whether we don't ... It's an expectation, it's what we do and they all just went well it's an expectation. There's never a question that they would not take a student. It is an expectation and when I say that it wasn't said as 'Oh we've got no choice', it's what we do. P2

Participant 5 who also spoke about an expectation, described it as a professional obligation which included the notion of the willingness to support the generations to come as important:

Professional obligation to support the undergraduates coming through and we all know as healthcare professionals that education and supporting our—the students, is part of our job. I also think the other factor is the willingness, the willingness of the existing practice nurses and the general practice as an organisation to support and the belief that supporting pre-registration nurses is important. P5

The CPPs also considered the manner in which the staff and students interacted as an influencing factor when making decisions about offering ongoing clinical placements.

Facilities want the students to feel like they are part of the nursing team. In order to facilitate this, they attempt to include the student in the day-to-day business of the unit and appreciate positive feedback from the students on the placements provided.

Participant 7 spoke of the aim in relation to creating a positive environment for the students:

We treat them as team—as health team members, that's ultimately what we try and engender in them, is that they feel part of the team. That they feel like they're valued and that they're making a contribution. And certainly I try and avoid the situation where they're not treated like that, I try and instil that and within the staff members too, that they're not used as work horses, which can be over—under certain circumstances that can occur ... And certainly I try and avoid the situation where they're not treated like that, I try and instil that and within the staff members too, that they're not used as work horses, which can be over-under certain circumstances that can occur. P7

Participant 6 had a similar comment:

They come in. They work alongside the staff. They're willing to learn. They listen to what they're being told. They have the (facilitator) around if there's a problem. So the staff actually get quite excited when I say okay it's coming up to that time of year we've got the uni students coming through. P6

Participant 5 describes how when students have a positive placement, word gets around:

A positive influence is that it gets around the student cohort (sic) that they're going to have a one on one [supervised placement], so in a hospital there might be one student to six different people, but in a general practice setting basically they're going to have a registered practice nurse with them all the time and access to 2 or 3 different doctors, just for them. ... and so they're really in a very privileged role, they're not diluted down with a dozen other students on a ward in a hospital. P5

Influence is a two-way street. The staff can have a positive or negative influence on the students and similarly, students can have a negative or positive influence on the staff. Some CPP who have experienced students who they perceive to have not been a positive influence said this is a contributing factor in considering further clinical placements for that education provider. Participant 4 spoke of their experience:

They've got to want to be here and I have had people on placement from other organisations and it's become clear to me that they're here for the wrong reasons, so I don't have them anymore. I—based on experience, the students [sic] want to be here and that makes a big difference. Where I've had the experience from another organisation whereby—and this is the same one, they obviously didn't want to be here, they were here for the wrong reasons, they didn't have—their capabilities in terms of interacting with others was not good and it just didn't work. So they've got—there's got to be the commitment and there's got to be that ability to interact. P4

The concept that nursing students could be perceived as a help or a hindrance to the facility was also a topic disclosed during the interviews. Participant 4 felt the students potentially decreased the physical workload of the staff as well as psychologically impacted on the staff:

I think it in actual fact makes it easier for them because there's a lot that the students can do to assist, even though it's—it's not a great deal of assistance, but the fact that there are more people around in itself, psychologically, helps the staff and there's—they can do a lot of the basic ADL's and they can work with other nursing staff. So in that regard it does lighten the load—the workload. P4

In contrast, Participant 9 felt that at times having nursing students within the health care complex did not *value-add* and therefore could become a burden if resources need to be provided for the placement:

If it became a negative impact on our business, our primary business is to—is a private healthcare facility. If that became a burden on our staff or our staff were unable—because there is a commitment, when you take a student it's not—it's not always value adding from a workplace, so it's also recognising that but while it's not value adding we see the end product, but if it becomes resource draining and burdening on our staff we'd have to review that because our primary role is to give appropriate care to our patients. P9

Participant 3 indicated they had considered the perception of student burden and had formulated a simple approach to helping clinical staff view student clinical placement differently:

What I think we need to do is we do need to talk to the staff more about students. I don't really think they're aware and they do see it a bit as a dumping, [it is] about highlighting for them what their role is and how important their role is because it is very important but I think a lot of the misconception is because they feel students are dumped on them and they don't really know what they've got to do with them. I don't know that our staff really see that as something they should do. I do think we have some registered staff who would absolutely embrace that sort of role ... they have a wealth of knowledge; we just need to convince them to share a little of it. P3

All participants in this research indicated that facilities have used the opportunity to offer clinical placement to pre-registration students as a chance to consider student nurses for recruitment purposes. This occurred whether it be for a graduate program at a future date or a more immediate position such as assistant in nursing (AIN) or personal carer (PC).

Participant 3 attested that it is one of the greater influencing factors in taking student nurses for placement. They describe how the Director of Nursing (DON) wants to market their facility to the students in the hope that they make application for a position when graduate applications are opened:

The reason that she participates and what drives her thoughts is with a view to recruitment and also to achieve that inside into recruitment because in her area obviously a square peg in a round hole doesn't work. P3

Participant 9 spoke about how their facility use the opportunity to employ the students in unregulated roles, with a plan to take them for a graduate year:

We'll employ them as a nursing assistant if we see someone who is a stand out student, so that we can capture them and also mould them and bring them through to a post-graduate year. P9

Participant 4 explained that their facility views students who have had successful placements as potential employees:

It's always been very positive and there is a proportion of students that say they want to work here and have applied to work here and when we've been able to put them on staff we do and it's advantageous to recruit from that source. P4

Participant 8 also spoke of students applying for positions after positive placement experiences:

A lot of our students come back and they'll often put their resumes in and say I really want to work here. And with the first year uni, once they've completed their first year of uni I can put them on as an AIN and I do. P8

The following participants' statement indicates a positive view to having pre-registration nursing students undertake clinical placement experience within their organisations.

Participant 7 voiced how it was considered a positive, whole of staff approach to receiving the students during their clinical placement:

I think our staff basically receive students with open arms and with goodwill already. I think the attitude of our staff towards students is great. They love having them there. Several of them are really good mentors and what I would regard—they could probably, if they wanted to move into an area that—similar to what I work in, they would be very successful I think. And generally by and large the whole attitude to—even people in hospitality, the whole hospital embraces students as such. P7

Participant 8 spoke about the value the students added for their residents, and the return value their facility added to the students. This was thought to be demonstrated by the thank-you notes students had given to the staff:

It's great, I just love having the students because it brings in—you've got those extra faces and those eager keen people that want to see what—how it's done. They want to learn and the residents love that. They love—they do love the staff and just recently because I've been—I haven't been here for 6-weeks, but when I came back I saw all these thank you cards up in the staff room from the students and they just loved the staff, because the staff are really keen to mentor these people. They like to show them how it's done and what to do and guide them through the routine of the day. P8

Participant 6 succinctly summed up how they value having students participate in clinical placement at their facility:

We've been quite fortunate because I think the groups of students we've had have been brilliant—they're seen as an asset not a liability. P6

If there is a perceived value of having pre-registration student nurses participate in clinical placement experience, this is an influencing factor in CPP offering placements for future nursing students to the Universities. However, if the placement has not been successful or has been negative, this is also an influencing factor in offering future placements. The perceived value of the placement is therefore an important consideration.

Supporting

During the interview process, participants regularly spoke of important issues that were factors when deciding if a facility would offer clinical placement for students. These were their capacity in relation to workload and optimal staff skill mix and the need for University supervisory support for the staff and the students during the actual clinical placement.



Figure 11: The Core-category Supporting and associated elements.

The capacity for an organisation to offer the placements requested by the education provider, appears initially to be an equation between how many student placements are requested and how many RNs are available to supervise. Participant nine simply states:

Number 1 we look at each of the units and their capacity to take students and how many they could take ... the staff that we have available to be preceptors, so the seniority of them. If you've got less skilled staff and your ability to take more students decreases so you've got to have good skilled staff to be able to manage a number of students. P9

Participant 7 considers that the staff the students are *buddies* with, makes a significant difference to whether placement will or won't be offered:

I do look at the staff I've got, who is on leave, who is not on leave because sometimes they're not going to learn as much from some of our casuals. So you want to make

sure they're with staff who are permanent part-timers or who have been with us for quite some time and they know the routine, they're reasonably experienced. So again that's always just to get a mix. Obviously we just can't take any number of students and we'd like to take more of course, but we can be restricted by what's going on within the hospital at the time ... patient numbers is a factor, I mean it's something we can't control. P7

Participant 2 spoke of the process the Nurse Unit Manager (NUM) of a busy paediatric ward goes through when they are considering offering placements:

Making sure that she hasn't had any attrition of staff that's going to be a problem in terms of skill mix ... appropriate skill mix and occupancy. Now [looking at] paediatrics, again because of the size of the unit, I know what drives that particular manager is just always making sure that she's got somebody (appropriate) who can be with that student, so it's skill mix [consideration]. P2

Participant 8, who had a higher percentage of unskilled workforce, has to consider which

University year groups' placement can be offered to. This is as a direct result of a limited RN workforce to supervise:

The skill mix—actually with the first years when we put them with the enrolled nurses on a day shift we would have 4 enrolled nurses and 1 RN. So yes, that would be probably an influential factor on how many we could take if they wanted—if they were to buddy with the ENs and RNs, the registered staff. If the University had mentors that could come and be with them I would be happy to take more.

The major influential factor would be the number of students that they would want to place, because I've only got a certain amount of staff that could take the students and buddy up with the students, so that would be the major factor. P8

Having adequate experienced staff to buddy with the students was a telling factor in decision making. Participant 1 made this common theme very clear:

Our ability to provide the placements depending upon the amount of RN supervision required. P1

Participant 3 indicated similar thought processes for their organisation:

Our staffing levels ... so if we can reasonably take on board supernummary people that can be adequately supervised then we determine our numbers that way. P3

There are many responsibilities resting with each and every registered nurse on each shift.

Participants felt that having students added a complexity to the RN role which can be often unrecognised and unaccounted for in workloads. Participant 1 illustrates the predicament:

Our RN's have, especially in age care and community ... the increased workload of having to manage unregulated workers. So it's also trying to balance their clinical workload with the workload that's required to preceptor a student. P1

Participant 1 further explains:

If services are feeling overwhelmed by the clinical workload sometimes they tend not to take students at that time ... sometimes the RNs feel that they just don't have enough time to provide a student a quality clinical placement with all the other stuff that they have to do. P1

Participant 5 also considered circumstances like the above when deciding to offer clinical placements for students within their facility:

The other thing is 'Oh we're too busy' to have a student, they will get in the way. P5

Participant 9 describes the impact of having students in more detail. They clearly outline the impact on facility staff in having a role in educating the student at the same time as providing nursing care to their patients. This participant suggests there must be extra supervision and support given by the Universities:

We need to recognise that we can't just have staff who are just on the ward also doing full patient cares, responsible for a student. So there needs to be another layer in there of supervision, so although those students can go off with a nurse for that day, there also needs to be someone who is available for solving the problem when things don't go well, the student that's not performing, performance management, the reports, because you can't put that back on the nurse who is actually doing the cares. P9

Participant 4 states that having or not having a supervisor provided by the education provider, has a major influence in the decision to offer clinical placements to pre-registration nursing students:

Without that supervisor, having the students here is another layer of responsibility for people like myself and I have to be constantly out there making sure that they're in the right place, that they're feeling satisfied, they're finding their placement rewarding, that they're not working unsupervised, that the staff here are taking care of them the way they should be. That they are following our procedures and policies. With having the supervisor here from the University who certainly knows [facility name] it takes a lot of that responsibility away from me because they're doing it. P4

The idea that facilities require support from the education provider was unanimous amongst all participants. Participant 6 recognises this by describing the importance of supporting the staff and students whilst the clinical placement is taking place:

We provide as much support as we can to keep them going through their nursing studies ... the presence of the facilitator and the fact that there is that external supervision. So, the impact for us here is it means that my registered staff on the floor are not occupied with the day to day supervision of students. They have an expectation that either my training officer or my nursing staff will do the supervision and then sit down with the students and ensure that their assignments and their questionnaires and their reports are all done and up to date. And we're just no resourced to do that. P6

They go on to further explain why having a University employed facilitator adds to the decision of offering clinical placement or not:

Having the facilitator there, the facilitator was able to sit the students down and say now this opportunity has arisen, you don't have to do it if you don't want to ... And she was there to provide that emotional support ... And engage with the students how they were managing while they were watching. The facilitators experience [sic], having the facilitator with them here would be definitely something—I've got used to that, so now when a University rings me and can't offer me that [Facilitator] it's kind of... I'm a bit hesitant. P6

Participant 4 unequivocally says that without an education provided facilitator or supervisor, they would not be able to offer clinical placement to pre-registration nurses:

If they didn't have a clinical supervisor and we didn't have sufficient registered nurses that would restrict us. It would be if you didn't—if they didn't have a clinical supervisor and we didn't have sufficient registered nurses that would restrict us, but to date we've been very, very fortunate. And I can't emphasise enough how beneficial it is to have a clinical supervisor from the University with the students whilst they're here. That has enabled us to take a margin number of students. We do have students from other institutions that do not or unable to provide a clinical supervisor and it makes it more difficult. P4

Participant 3 indicates within their organisation a facilitator is a deciding influence in the provision of placements:

They (students) need a registered nurse there that they can refer to as a resource and who can—and who is supervising everything that's going on rather than the carer or an enrolled nurse. I mean if we have adequate numbers of RNs then certainly that would be alright, but the University would have to provide the facilitator. The availability of myself to supervise them, because that's part of the role for me, facilitating students. Supervising students is different. I think a student needs to have an appropriate resource person on the floor with them and that would be a registered nurse; [in summary] our staffing levels and the availability of the educator to be there to supervise them.' P3

Some universities already utilise the concept of a University facilitator overseeing preceptors from industry in support of the student's clinical placement experience. Participant 5 sees the

picture from both sides as they periodically work in a facilitation role. This gave this particular participant a greater understanding of curriculum and learning objective needs which can be challenging for some clinical staff:

I work as a facilitator with the University as a joint appointment between the uni and the (facility name) and so I'm there to actually support the practice nurse in the practice. I'm there to support the student as well ... there to ensure that the student knows the parameters, is there on time, wears the proper uniform, knows the code of conduct of behaviour, writes up the clinical book, gets the full reports—academic reports and clinical reports in on time and all the marking [assessment]. Sometimes you can be professionally isolated in the general practice setting and geographically isolated, and so having a student and being expected to take on this teacher role and then be a preceptor as well and give them constructive criticism or if they're just not cutting the mustard, provide their performance feedback, it is really quite intimidating. P5

Through this position, Participant 5 supported the facility staff as well as the students during the clinical placement. Simultaneously this person also undertakes the assessment requirements to lessen the load of the RNs:

So we actually do have—yes that might be a big influential factor as well, not only the relationship but the Medicare Locals built up with the practices here, but also, yes we've got that support model. We make it very clear right from the word go that I'm here to support the practice nurses and the student and I pop in regularly. If there's any issues with performance of competence I'm there to support the nurse, the student nurse and the practice nurse and work through any competence issues. The practice nurse does not have to take on those extra skills and responsibilities, which a lot of nurses actually are frightened of. P5

Participant 8 describes the support they get from the universities:

Yeah the University does provide an educational facilitator and they are here for the entire shift but it enables that student to buddy with a staff member and gain continuity throughout their placement. P8

Participant 7 who does not have the advantage of a University facilitator describes how they support and supervise the students:

Ideally students would be buddied with an individual nursing staff member, one on one ... Yes, they're buddied with—they're buddied with RNs, enrolled nurses. But obviously that sometimes cannot occur so they have to share mentors. For that reason, I personally have a very hands-on approach and I'm very involved with being in the ward areas, all ward areas, all day, with the students ... if they're in the first year for example, they're buddied with appropriate assistants in nursing, with broad experience, so those people are selected, who I think would be appropriate to be

buddied with those students. Ultimately they're supervised or ultimately it's the RN that's responsible and myself. P7

A solution to this dilemma in supervision and support appears to be improved with professional development aimed at educating staff in the practice of facilitating learning as

Participant 1 suggests:

Getting the universities out to the RNs and showing them what competency they want completed and what each assessment tool actually means so since we've had some training from universities going out to services I think that's improved but I think it's just knowing how to fill in the form, rather than completing it. P1

Participant 1 indicated that when the support from the education provider was easily accessible, she considers offers of placement far more closely:

The clinical lecturer contact time, so if they're saying that they will provide a clinical lecturer either on site or off site, is a big thing, so providing more contact time would be good...that definitely comes into consideration for me when I have feedback from certain students saying that their unis don't provide enough facilitator time, that definitely comes into consideration when I'm placing students, if I'm worried about that uni, if they're going to provide the appropriate supervision from the University side of things. I consider the placement more because there's less administration and things that they're [staff] responsible for. P1

When asked if there were any definite barriers to offering clinical placements for pre-registration nursing students, Participant 4 expressed very clearly that supervision and support of the students through University provision would be the influencing factor:

The only think that comes to my mind would be provided there was supervision—a supervisor provided from the University, we could take on more. Everything else, all the groundwork is done. We like having the students here, the staff likes having the students here, they know how to look after the students, they know the role boundaries Yeah it would just come down to the supervision and support for the additional students and we would be—we would struggle to do that. P4

The data indicated whilst organisations and individual RNs on the wards were positive in offering students a placement for pre-registration nurses, they required additional support through a clinical facilitation role, provided by the University to enhance and improve clinical capacity. In summary, Clinical Placement Providers want a strong relationship with the Universities they offer places to.

This meaningful relationship needs to be developed through exceptional and effective communication, involving mutual understanding and collaboration from both CPPs and universities inclusive. The education of the future Australian nursing workforce must be a collaborative exercise; a dual responsibility. Pre-registration clinical placement must be valued as an important part of the nursing students' education by both stakeholders and negative attitudes including feelings of burden must be eradicated for positive and exciting learning to take place. Supervisory support from universities during the actual clinical placement is of utmost importance as is support for ground staff in their daily workloads and skill mix capacity.

This chapter gave an overview of results to the research question *What influences industry to offer clinical placements for pre-registration nursing students?*. The chapter commenced with an explanation of the core concepts derived from the data and an introduction to the central category of the **Strength of the Relationship** which emerged as a result of the constant comparative method of data analysis. It explored the three important core categories that inform the central category including introduction to the major concepts informing the core categories.

CHAPTER FIVE

Discussion

The preceding chapter presented the findings of this Grounded Theory study. The aim of this study was to develop a substantive theory that presents an understanding of the factors that influence industry to offer clinical placements for pre-registration nursing students.

The WHO has called for higher education to be the global standard for nurse education (WHO 2009). Gillett (2010) as previously alluded to, found that incorporating nurse education into the higher education sector, inevitably has implications for the relationship between universities that educate nurses and local health service providers. This is as a result of the latter providing the mandatory clinical placements for nursing students. In addition, Gillett (2010) also asserts such implications are a result of all groups seeking to influence nurse education, as they have their own agendas and nurse education has to manage those agendas.

Understanding the factors that influence industry to offer clinical placements for pre-registration nursing students will afford higher education and health services providers' valuable information to assist in ensuring appropriate clinical placements continue to be offered for pre-registration nursing students. To illuminate this, the chapter begins with an explanation of the substantive theory. This is followed by a comprehensive discussion of the study findings within the context of existing literature. Such engagement with the literature serves to endorse the theory's contribution to nursing knowledge.

The substantive theory: 'Relational Strength'

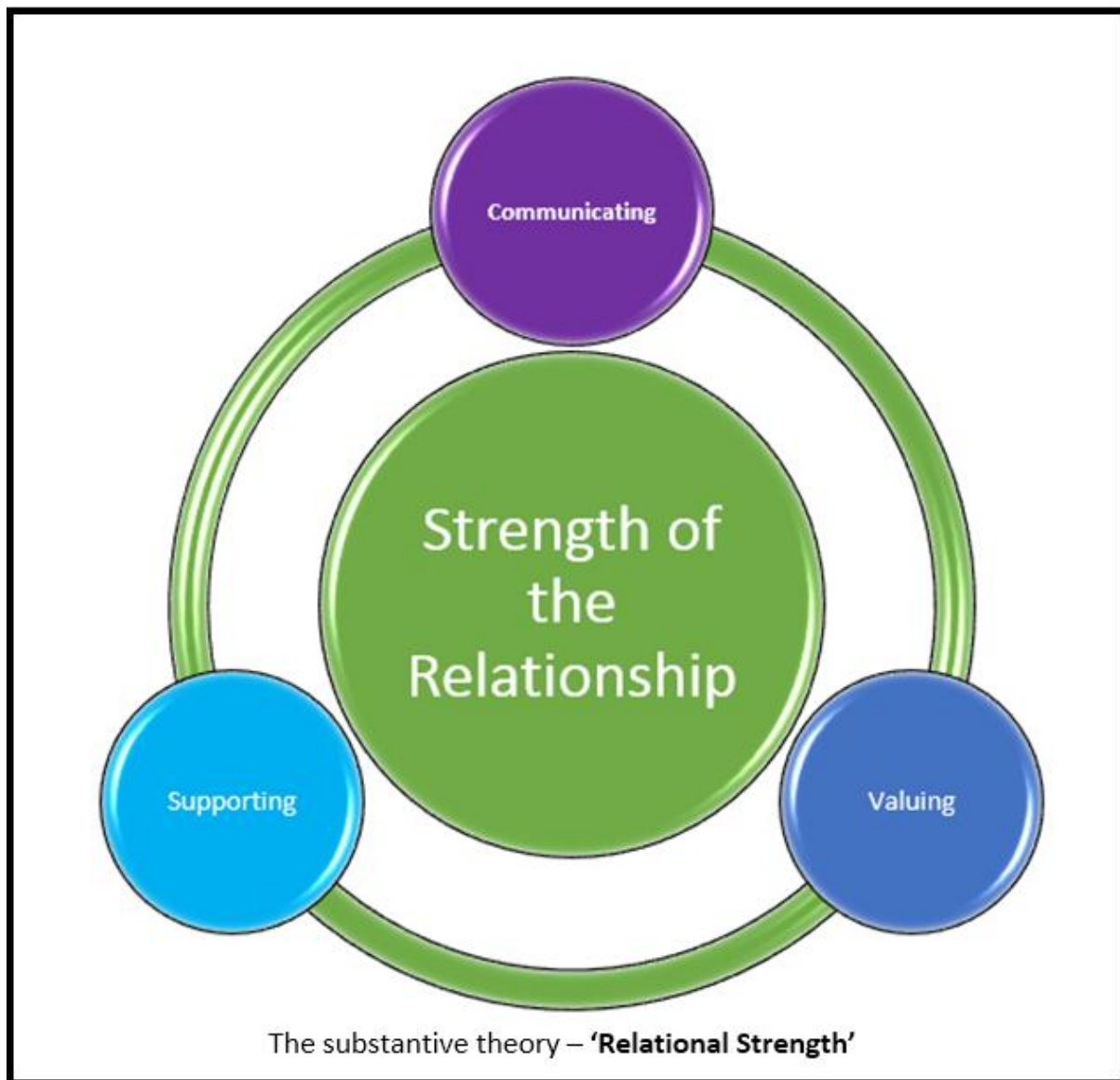


Figure 12: The Substantive Theory.

The substantive theory that emerged from this Master's research is: '**Relational Strength**'.

This substantive theory asserts that the primary influence when offering clinical placement for pre-registration nursing students is the **Strength of the Relationship** between the universities and the CPP.

As described in Chapter three, Grounded Theory is a systematic research approach involving the discovery of theory through data collection and analysis (Engward 2013). By using a Grounded Theory approach, the substantive theory emerged from the data, obtained through

interviews with the person/s in industry who makes the decision to offer or decline clinical placements to universities for their BN students. These people are referred to as the CPPs. CPPs are often clinicians working in roles such as Nurse Unit Managers (NUMS), Clinical Nurse Consultants (CNCs), Nurse Educators (NE) and DONs.

The participants who gave of their time to be interviewed for this research, were those who interact closely with the University in procuring placements for clinical experience for pre-registration nursing students. Demographics included four Directors of Nursing, three Nurse Educators and two Practice Managers. It is therefore, the realities which emanate from the constructs of their own experiences that enabled the researcher to gain an understanding of the factors that influence industry to offer clinical placements for pre-registration nursing students. From this, the substantive theory was developed.

‘**Relational Strength**’ provides new insights, knowledge and understanding regarding the elements required to maintain a strong relationship between universities and CPPs in pre-registration nursing education. As elucidated in the previous chapter, universities need to have a strong relationship with their industry partners, the CPPs, to ensure appropriate clinical placements continue to be offered.

Comprehensive interrogation of the data facilitated the emergence of the central category; the **Strength of the Relationship**. Relationships are important but as Hutchinson and Purcell (2010) reminds us, the mere existence of a relationship does not necessarily mean that the relationship quality is strong. A strong relationship has the elements of frequent and meaningful engagement on all levels, shared vision and mutual goals, clear expectations with shared responsibility and a culture of trust and respect (American Association of Colleges of Nursing (AACN) 2012).

The central category, the **Strength of the Relationship**, contends that through effective communication and meaningful partnerships, hurdles can be overcome, miscommunications righted and positive interactions will be remembered before negative ones. The **Strength of the Relationship** is informed by three major elements, Communicating, Valuing and Supporting. These elements describe the factors that impact on the **Strength of the Relationship**, and in turn, the offer of clinical placements for pre-registration nursing students.

The central category: Strength of the Relationship

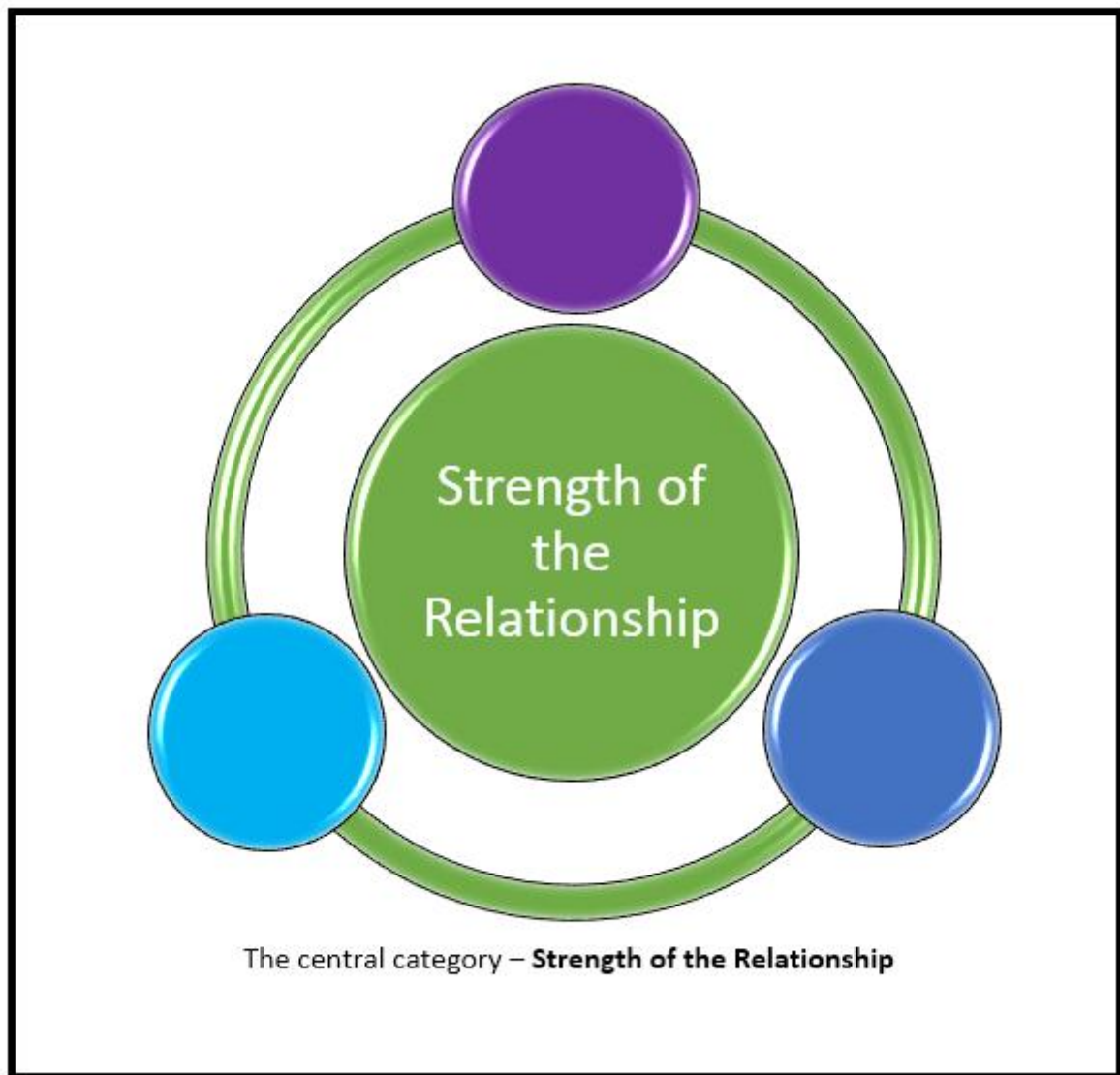


Figure 13: The central category: Strength of the Relationship.

Participants in this Master's study described the relationship between the universities and the CPPs as one that should replicate that 'of a good marriage', that is, the relationship must aim to meet the needs of both parties.

The literature validates the importance of this relationship in relation to nursing education (Beal et al. 2012; Henderson, Briggs, Schoonbeek and Paterson 2011; Gillet 2010). Indeed, a qualitative study conducted in San Antonio, Texas, USA by Beal et al. (2012) with 170 nursing leaders, reported that developing and sustaining academic–practice partnerships is difficult and that the key element for any partnership is the relationship. The research cited above revealed that the relationship must be based on mutual respect and trust and partners must share a vision and mutual goals for the partnership to work (Beal et al. 2012).

Participants within the current research described positive and negative factors that impact on '**Relational Strength**'. Positive factors included quality communication, mutual understanding and partnership, willingness and support. Factors that impact negatively on the relationship include poor communication, unapproachability and a lack of knowledge about the health care industry or facility. In addition, another negative was the perception of students as extra work and burdensome. Many of the findings within Beal et al.'s (2012) study, have also been identified within this study of *What influences industry to offer clinical placements for pre-registration nursing students?*. These are elucidated in greater detail, later in this discussion.

Two professional USA nursing bodies, the American Association of Colleges of Nursing (AACN) and American Organisation of Nurse Executives (AONE) have partnered to form the AACN-AONE Task Force on Academic-Practice Partnership. Otherwise known as '*The Task Force*', this organisation was specifically charged with developing a document that generates a roadmap for nurse leaders. The roadmap is designed to develop and sustain

effective academic–practice partnerships and contends that collaborative relationships between academia and practice are established and sustained through:

- the establishment of formal relationships
- shared vision and expectations that are clearly articulated and
- mutual goals.

Respect and trust are highlighted as the cornerstones of a collaborative relationship and must include open communication, frequent engagement, mutual investment/commitment and transparency (AACN 2012). Beal et al. (2012) asserts that a close relationship between education and practice providers has many benefits to both partners. Some of which include a more systematic and formalised approach to collaboration, thereby facilitating better access to clinical placement opportunities.

This research also identified that collaboration is paramount. Relationships are strengthened through a culture of supporting the learning environment with the sentiment and appreciation that student learning is a dual responsibility; one necessary for the future of the nursing workforce. This is supported by Evans et al. (2013) who recognised frequent communication and collaboration between the University and the CPP facilitator is essential to the success of any of the teaching/learning models in the clinical environment. As a result of a truly collaborative relationship clinical placement offerings could be maximised to cope with the ever increasing demand. The central category—the **Strength of the Relationship**—was informed by three elements. The following section of this discussion will therefore consider the elements that inform the core category.

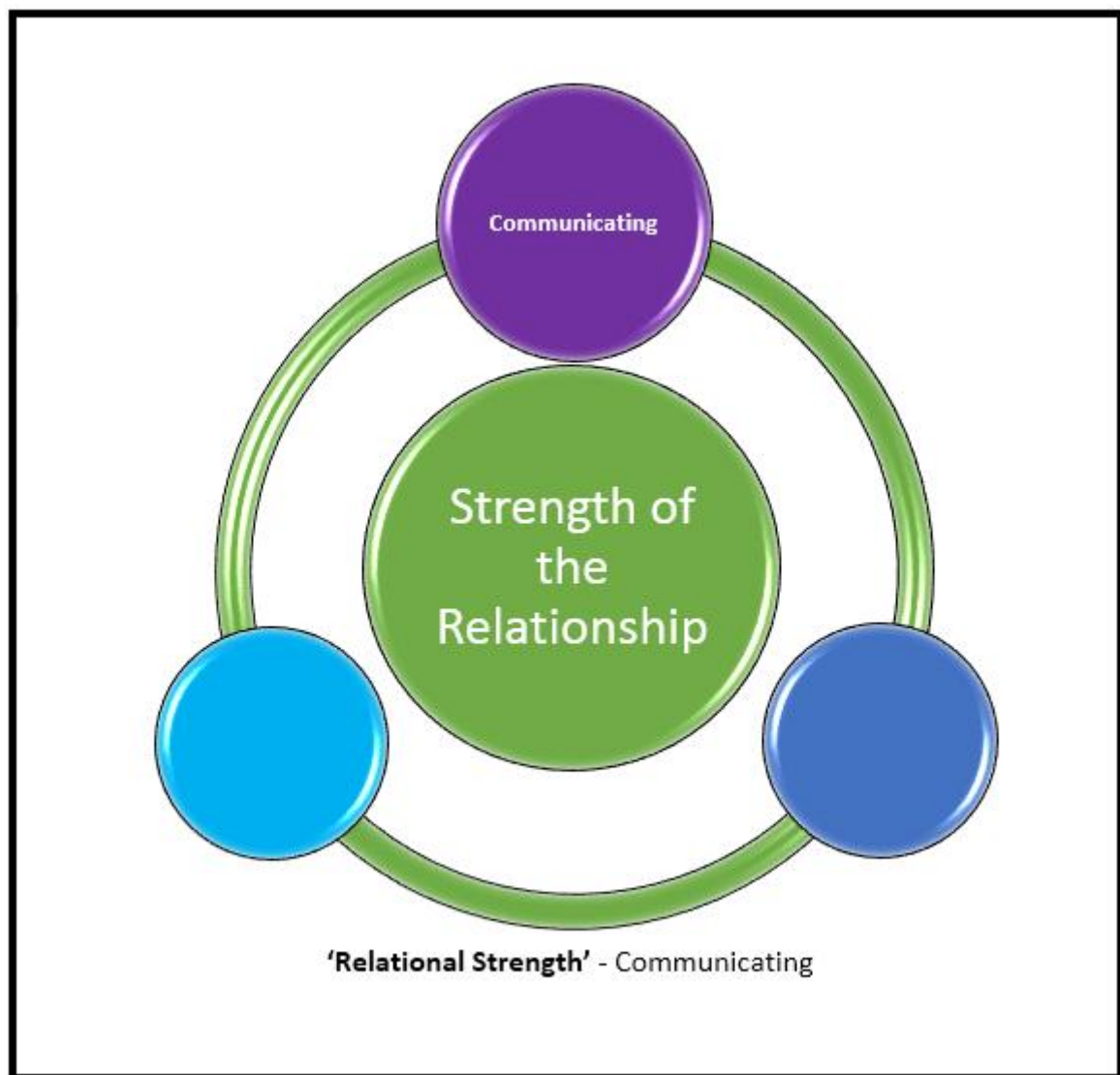


Figure 14: 'Relational Strength'—Communicating.

Jeffries and Milne (2014) conducted an Australian study, which explored communication practices on the part of tertiary institutions in relation to clinical placement. Seventy-one participants from 58 host organisations were interviewed, all of which had experience of hosting students from a range of tertiary institutions. Results were convincing that effective communication is important for successful clinical placement outcomes. The authors also identified that a small but considerable number of CPPs were not satisfied with the communication practices of some of the universities with whom they worked (Jeffries & Milne 2014). Importantly, this Master's study also established that communication and

collaboration between universities and the CPP is central to securing clinical placements for pre-registration nursing students. Mandatory requirements of clinical placement during pre-registration preparation, highlights the importance of forging successful relationships with industry (Jeffries & Milne 2014). Universities are entrusted with producing health care graduates that are competent and able to adapt to changing clinical environments (Warner, Jelinek & Davidson 2010), an integral part of which is the clinical experience. To that end, the ANMAC formally the Australian Nursing and Midwifery Council (ANMC) have the primary purpose of accrediting nursing courses throughout Australia ‘... to provide assurance that every graduate has in fact achieved the agreed standards’ (ANMC 2009, para. 3), which is inclusive of clinical placement experience.

The findings from this Master’s study with regard to the need for beneficial communication to enhance effective partnerships are clearly supported in the literature. Henderson, Heel and Twentyman (2007) claim effective partnerships are dependent on professional communication and collaboration between parties. Clear delineation of roles and responsibilities are essential to ensure good working relationships between partners and each party also needs to be able to contribute to meeting the needs of the common goal; in the case of RN education, to produce quality, safe nursing graduates (Taylor, Brammer, Cameron & Perrin 2015). Jeffries and Milne (2014, p. 565) aver that ‘... it is widely understood that good communication underpins successful clinical placement programs’. Participants in this Master’s study communicated similar sentiments to those found by Jeffries and Milne (2014), with their comments indicating that good communication was a key element in establishing effective working relationships.

Ticehurst and Downs (1999, para. 4) outlined ‘professional communication to be intentional communication that has the objective of achieving strategic goals within organisational or professional contexts’. Within this context, Ticehurst and Downs (1999) explained that

practitioners need to consider communication as a core organisational process and be able to link communication to organisational outcomes and strategies. Sewestianiuk and Voitovici (2013) found in their study titled '*Managing Strategic Communication*', that although communication was considered as a most important function of daily organisational routine, it often sits in the shadow of other technical or more business oriented practice and this is to the detriment of management processes. Ticehurst and Downs' (1999) research investigated the richness of different internal communication channels in relationship with the processing of an efficient communication strategy at Ericsson Göteborg, a large international organisation based in Sweden. The researchers found that organisations neglect communication aspects of their professional practices by taking communication acts for granted, considering them an element of habit in solving problems and managing team work (Sewestianiuk & Voitovici 2013). Significantly, participants interviewed for this study articulated insight into the risk that neglecting communication can have, on working relationships.

The participants expressed how universities need to communicate more meaningfully with health services in order to operationalise clinical placement opportunities for pre-registration students. Participants believed that by strengthening and improving communication, true collaborative partnerships would be forged and that this is a key to '**Relational Strength**'.

A study conducted by Landry, Lee and Greenwald (2009) in San Francisco, that examined a collaborative project between three schools of nursing which aimed at increasing interest in public health nursing among pre-registration nursing students, focussed on the goals and outcomes of the respective institutions. Landry et al. (2009) examined how the collaboration worked to establish linkages and ongoing communication between the stakeholders to afford educational opportunities for students in pre-registration programs within community and public health nursing facilities.

Landry et al. (2009) found that although the nursing programs attempted to be respectful of previously existing relationships with other University programs, communication between nursing schools at various institutions was limited. Preceptors and nurse managers within industry fielded numerous phone calls requesting specific clinical opportunities for students. The Landry et al. (2009) study enabled nursing faculty to more fully appreciate the importance of good communication and that there could be several potential positive outcomes in opening up effective lines of communication. These included the development of a streamlined process for obtaining clinical placements and identification of projects that could be collaboratively undertaken.

Henderson, Heel and Twentyman (2007) suggest that open channels of communication where each partner identifies its needs and priorities, has further reaching benefits than just increased capacity to offer clinical placements. Results from the Henderson et al. (2007) study which was conducted in Brisbane, Australia also identified increased hospital staff satisfaction through greater involvement by them in the education of students. Furthermore, it revealed that effective communication and enhanced understanding by clinicians of the student placement process which contributed to improved satisfaction and outcomes for the students.

Similar to the study done by Henderson et al. in 2007, the outcomes of this Master's study identified that offers of clinical placement by industry rely upon clear and effective communication between the universities and the CPP. Clarity of communication is required as each organisation has its own goals and agendas which need to be navigated but both have the common goal of delivering nursing education. Jeffries and Milne (2014) assert that the importance of clinical placement partnerships is widely acknowledged by universities as paramount, yet knowledge of what is really happening in these relationships is not always obvious at an institutional level.

Gillett (2010) proclaimed in her United Kingdom (UK) study which explored changes to the relationship between universities and the UK National Health Service (NHS) that ‘... for a partnership to be successful there has to be co-operation, trust and a sense of a linked future’(p. 3). The UK study reviewed the wider debate around partnership policy and drew upon the debate to evaluate the way that universities and the NHS were working in partnership to provide clinical practice placements for nursing students. Gillet (2010, p. 3) explained how the relationship between the NHS and universities required ‘... clarity of purpose and agreement through clear communication’.

Similarly, Landry et al. (2009) identified in their study, once mutual goals become apparent within the clinical placement relationship, local nursing faculty wanted to re-establish organisational alliances and create effective communications between the health department and the nursing schools. This is an important finding and one that has been reiterated in the responses from participants in this study.

As conveyed in the findings chapter, many participants described that when communication was *ad hoc*, both parties found difficulties in planning, implementing and evaluating clinical placements for pre-registration students. Hence, when these difficulties are identified in the first instance, industry is reluctant to offer clinical placements to those universities whereby the communication was perceived as inadequate and ineffective. This is clear indication of how important it is to communicate effectively. Henderson et al. (2011) considers good communication vital for building the relationship, with dialogue needed between clinical settings and universities if staff and students are to maximise learning opportunities through offers of clinical placement.

Cooke, Walker, Creedy and Henderson (2009) advocate that interactions between students and RNs are crucial opportunities for clinical learning. Success of this learning partnership is

built on exceptional communication, negotiation and shared goal setting, but these facets are often difficult to achieve. Henderson et al. (2011) found through effective communication including frequent feedback, RNs are more likely to be responsive and open to collaborate with universities to assist students during clinical placement activities. Taylor et al. (2015) asserts appropriate structures and processes have to be in place to enable the continuous communication and collaboration needed for both the universities and CPPs to address learning needs of staff and students, monitor outcomes, and engage in dialogue about how they can successfully address the learning issues that emerge. Reid-Searl and Happell (2011) in their Australian study, also found quality communication to be crucial in providing RNs with information about what students were able to do to ensure safe and effective learning experiences.

In summary, an effective communication style which is based upon mutual understanding is necessary and of mutual benefit to both parties. This study of *What influences industry to offer clinical placements for pre-registration nursing students?* found that effective communication entails mutual understanding and a willingness to work together in a collaborative partnership, emphasising mutual interests and reconciling mutual differences. Whenever two parties want to achieve a mutual goal, then clear communication with regard to needs and perceptions of each other's requirements is of the utmost importance.

To elucidate this further, the discussion in this chapter will focus on Collaborative Partnerships and Mutual Understanding, two major elements that inform the element of communication and their connection to the core category; the **Strength of the Relationship**.

Collaborative partnerships and mutual understanding.

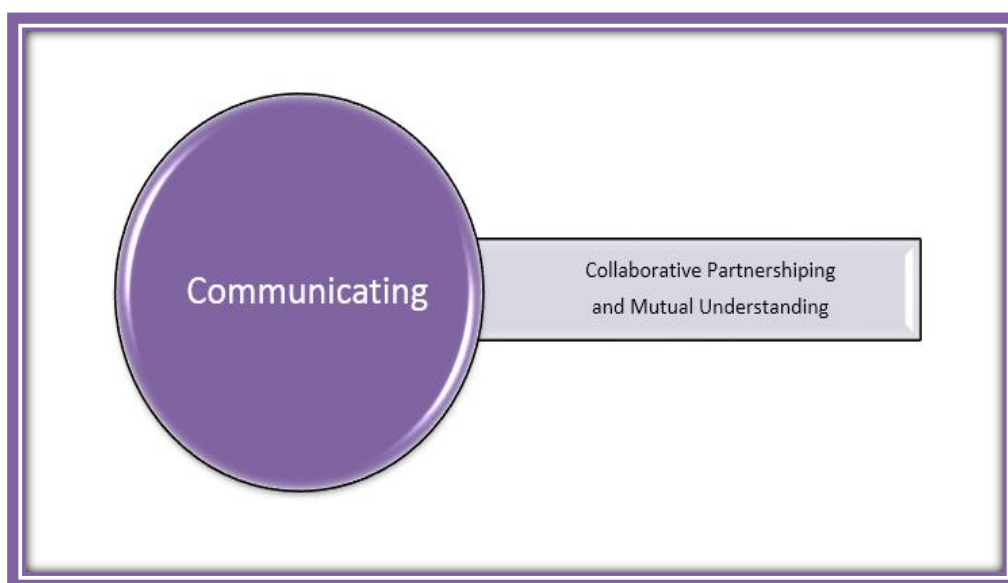


Figure 15: Communicating and major elements.

The results of this study identified that a major element when considering offers of pre-registration clinical placement for nursing students included the need to communicate effectively. This entails collaborating meaningfully to develop a working partnership that shares mutual understanding of the goals. By maintaining strong communication and a collaborative partnership between the universities and the CPPs, a strong joint effort of engagement from both stakeholders, will ensure students' needs are met during placement. Without a meaningful partnership, offers of clinical placement can be impacted on, as the onus of the placement is felt individually by the health care facility and students become perceived as burdensome to the organisation (burden will be addressed further, later in this chapter). Preparing nurses who are fit for practice, purpose and academic award is a key issue for nurse education partnership providers (Malik & Hunt 2007) and this can only be achieved through the continued offers of clinical placement to pre-registration nursing students.

Gillett (2010, p. 197) offers the description of partnership to be 'collaboration between agencies to accomplish a common goal'. Beal et al. (2012) also asserts that a successful partnership includes mutual trust and respect, shared vision and goals, equal and ongoing

commitment to the partnership and open, honest, and forward communication. Collaboration in health care is described as ‘health care professionals assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans’ (Henderson et al. 2011, p. 200).

Partnerships between health care facilities and tertiary institutions can provide direct opportunities in shared learning and collaborative relationships for staff and students (Henderson et al. 2011, p. 200). Cooper, Orrell and Bowden acknowledge that, ‘... without strong and effective relationships between the University and workplaces there can be no work integrated learning, as this type of learning involves complex and intense purposeful interpersonal and administrative activity’ (2010, p. 177). Henderson et al. (2011) maintains that learning in any form is dependent on robust partnerships between universities and health services. In a successful partnership, knowledge is shared between partners and there is a united shared commitment to lifelong learning that includes ‘... maximising the potential of each nurse to reach their highest level within his or her individual scope of practice’ (p. 201).

Nurses, as early as the 17th century have a long tradition of successfully partnering with others (Beal et al. 2012). Early partnership collaborations were formed primarily with religious communities and then later with physicians, hospitals, the armed forces, universities, and professional organisations (Beal et al. 2012). Helmstadter (2009) suggests that the boundaries between nursing, medicine, religion and domestic service were fluid in mid-nineteenth-century England. During this time Anglican nursing sisters were beginning to discern between professional nursing and the traditional role of nurses as domestic servants who looked after sick people as one of their many duties. Medical doctors were looking for more knowledgeable nurses who could carry out medical practices competently. As such collaborative approaches or partnerships were required for effective patient care (Helmstadter 2009). The ultimate outcome of a nursing curriculum is to graduate RNs to provide safe and

effective nursing care for patients. Therefore, just as many different relationships were required for effective patient care historically, so too partnerships have to be forged in recent times, as the education of students and the role of nursing evolves in the modern age.

Since the movement of nursing education to the tertiary sector, efforts have been made to progress positive working relationships between universities and healthcare institutions (Touhy 2011). This can be observed in a number of ways, but that which directly relates to this study is principally in the negotiation and offering of clinical placement opportunities for nursing students (Touhy 2011).

There is a plethora of evidence that robust partnerships need to be developed to create positive learning environments (Peters, Halcomb & McInnes 2012; Grealish & Smale 2011; Henderson et al. 2011). Creating and sustaining the environment within which safe practices can flourish requires a co-ordinated, multipronged approach. Such an approach would be considered as a partnership. Edwards and Wilkinson (2014) propose partnerships ought be regarded as a process, rather than a stand-alone outcome.

Hudson and Hardy (2002) suggest that a successful partnership is only possible if all the partners acknowledge there is a real need for the partnership. Partnerships require interdependence and they suggest that in the case of nurse education and clinical placements, neither party would be able to resolve problems in isolation. Gillett (2010) endorses this when she states ‘... true partnership comes when the partners are otherwise independent bodies and agree to co-operate to achieve a common goal, create a new organisational structure or process to achieve the goal, plan and implement a joint program and share the relevant risks and rewards’ (p. 201).

In situations where there are unequal power arrangements, it can prove difficult to sustain collaborative partnerships (Edwards & Wilkinson 2014; Hall-Lord, Theander & Athlin 2013).

Tope and Thomas (2007) authors of '*Creating an interprofessional workforce: an education and training framework for health and social care in England*', identified that the relationship between tertiary providers and healthcare providers is not always an equal partnership, as it is usually the universities that control the degree of collaboration, curriculum content and its delivery. It is also often academic staff who assume the principal role in the final assessment of professional competence. This could be considered by some to undermine the professional status of nurses working in clinical areas and the value of the practice component of BN programs. Tope and Thomas (2007) believe such actions could contribute to perceptions of an unequal relationship. It is mutually beneficial and important for the nursing profession as a whole to work together in developing and actioning a curriculum that meets the needs of its community through mutual understanding and collaborative partnering. Dawson, Brodie, Copeland, Rumsey and Homer (2014) maintain that partnering has been noted as an important concept in collaborative practice. The collaboration between universities and CPPs has repeatedly been highlighted as a vulnerability of nursing education, where lack of communication and agreement between parties involved in the students' learning is described as a serious problem (Hall-Lord et al. 2013).

The strength of many of these partnerships is thought to be fragile. Hall-Lord et al. (2013) contend there is often minimal or irregular communication and little understanding shown to meeting common goals through shared resources and vision by the universities and CPPs. This lack of strong partnership can influence offers of clinical placement to pre-registration nursing students, because the foundations to partnership in nursing education are not significantly cemented. As such, the partners cannot create a sustainable learning environment for clinical placement and therefore offers may not be forthcoming.

In 2010, the National Council for Accreditation of Teaching Education (NCATE) in the USA, commissioned a report into changing teaching education to focus on developing programs that are fully grounded in clinical practice and interwoven with academic content and professional courses. The report '*Transforming teacher education through clinical practice: a national strategy to prepare effective teachers*' emphasised that in order to make this change, teacher education programs must work in close partnership with school districts to redesign teacher preparation. This better serves prospective teachers and the students they teach. The report stressed that partnerships need to include shared decision making including surveillance on candidate selection and completion by school districts and teacher education programs (NCATE 2010).

NCATE (2010) recommended that by creating systems built around programs centred on clinical practice, it would advance shared responsibility for teacher preparation, support the development of complex teaching skill and ensure that all teachers know how to work closely with colleagues, students, and community. This current study of *What influences industry to offer clinical placements for pre-registration nursing students?* also found that a key element to ensuring offers of clinical placement opportunities to nursing students, is through collaborative partnerships and working together to prepare nursing students for practice.

In summary, as the above discussion which has engaged with the appropriate literature suggests, collaborative partnering assists in the planning and offering of clinical placements. Collaborative partnerships include attributes such as common visioning and goal setting, approachability and a genuine desire to immerse the student into the health care environment. The benefits of the University truly knowing and understanding the health care organisations goals and mission that they request clinical placement from, including their philosophy and everyday business cannot be understated. By knowing and understanding the CPP,

participants in this study communicated that requests for clinical placement dates, particular wards, student numbers and the like, would be given greater consideration.

Effective communication is critical to the development of mutual understanding between professionals and their patients (O'Daniel & Rosenstein 2008; Tan 1994). The processes, by which this mutual understanding is achieved, however, are not well understood. One participant in this Master's research commented that when they are approached by a University with an unrealistic request for clinical placement, they often say no as they don't feel the University requesting the placement, knows or cares about the restraints already experienced in that particular health care organisation.

Mutual understanding is a state that arises from effective communication processes which result in the achievement of shared goals (Tan 1994). This understanding establishes a sense of purpose in partner's interactions. Mutual understanding emphasises the need for shared meaning and shared meaning occurs when there is an exchange by which the meaning of something corresponds to an already existing meaning of another (Jebreen & Symonds 2011).

Essential to any effective relationship is mutual understanding by partners of each other's goals, methods of operating and an appreciation of their respective differences as well as similarities. At the same time, it is also important that partners share similar values and philosophical approaches. In particular, and in the context of this study, it is a commitment to the profession of nursing. The aim is to work towards achieving joint gains and identifying opportunities for 'win-win' outcomes. Similarly, partnership is underscored by its extent to aid in mutual problem-solving through deliberate means (Edwards & Wilkinson 2014)

An integrative review conducted by Dawson, Brodie, Copeland, Rumsey and Homer (2014, p. 400) that analysed collaborative and partnership approaches towards midwifery capacity building in developing countries, concluded that:

... a number of factors were found to be integral to maintaining collaborations including the establishment of clear processes for communication, leadership and appropriate membership, effective management, mutual respect, learning and an understanding of the context.

The construction of a collective identity where the goals of individuals and the organisation are shared, has been noted as critical to the development of collaborative relationships and the achievement of organisational objectives.

This study found that through mutual understanding, decisions are informed by the common goal, which almost always is to get the best placement experience for the student nurses. At times, this requires compromise from both parties within the partnership. This suggests that when the '**Relational Strength**' within the partnership is strong, decision making in respect to offering clinical placements to nursing students is optimised.

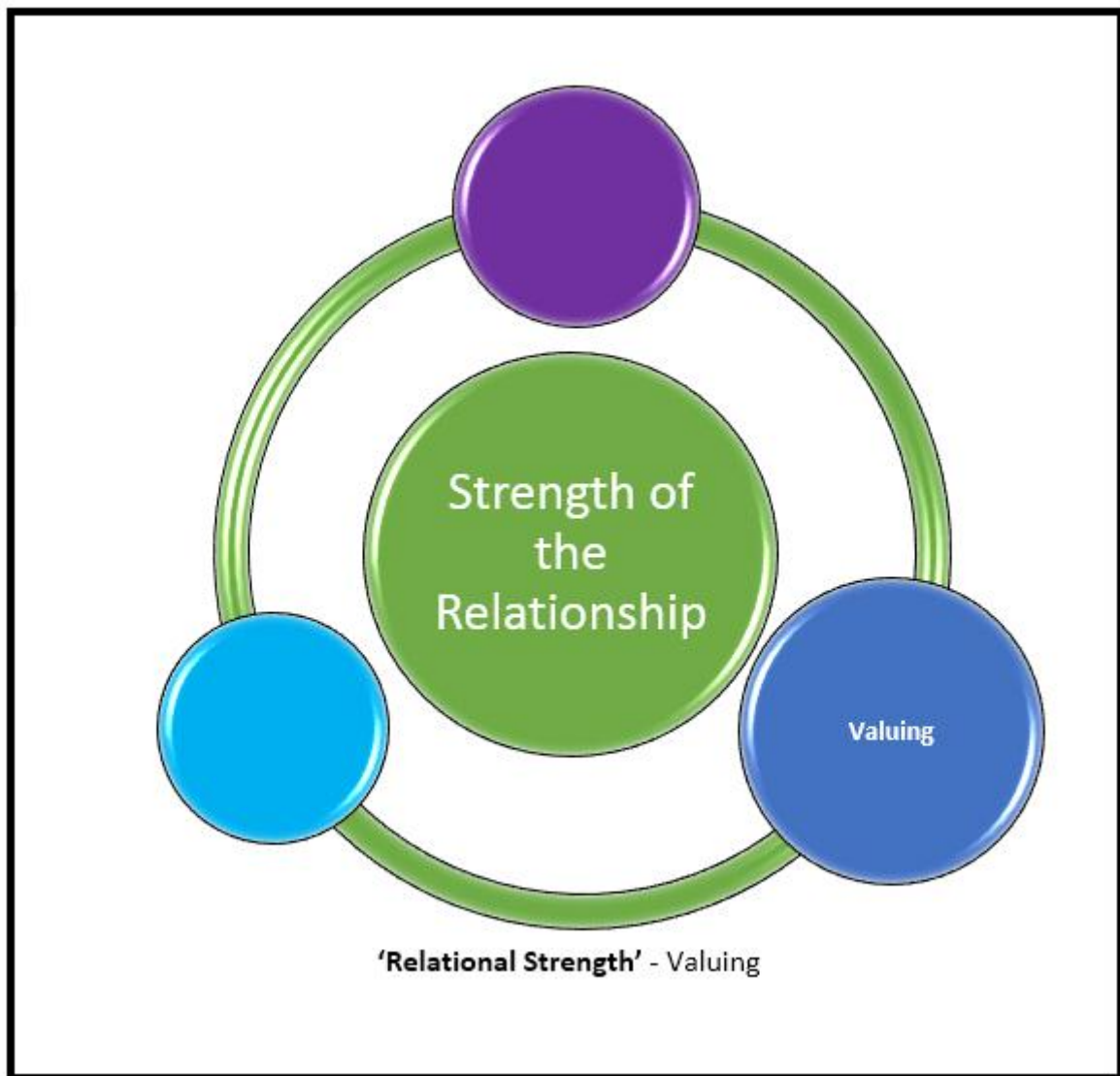


Figure 16: 'Relational Strength'—Valuing.

The **Strength of the Relationship** requires the partnership to recognise and value the importance of undertaking of clinical placements for pre-registration students as this is where the clinical preparation for practice occurs. Through a 'can-do' and positive attitude toward hosting students for clinical placement, each member of the partnership will benefit by working together to produce safe, competent nurse graduates. Alternatively, by viewing student nurses and clinical placement as an added financial and human resource burden to the facility, then negative interactions are bound to surface.

Applying the principles of '**Relational Strength**' will result in the creation of a distinct culture that values and integrates the unique characteristics of each partner's core business. Partnerships between universities and CPPs that recognise and value the benefits and strengths that can be derived for the nursing profession from such an alliance, are increasingly evident. In fact, some health care organisations in Australia have increased offers to pre-registration nursing students, with organisational intention to survey for possible post-graduate candidates.

Clinical placement is instrumental in shaping student learning (Cooper, Courtney-Pratt & Fitzgerald 2015; Arieli 2013) and there is correlation between how an organisation values clinical placement and the student experience. The Willis Commission of 2012 was instructed to report on essential features of pre-registration nursing education in the UK, and what types of support for newly registered practitioners are needed to create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services. The report, '*Quality with compassion: the future of nursing education*', gathered evidence on the best methods of delivering pre-registration nursing education in the UK and how efficient the current education system was. In particular, it examined the balance between workplace and classroom learning. The report indicated that a culture that values and respects education will naturally be committed to supporting the next generation of nurses. Positive attitudes held by RNs enable pre-registration nursing students to overcome challenging emotions that might otherwise get in the way of settling in and learning to nurse (Willis Commission 2012).

Development of dynamic workplace cultures, in which change is embraced as the norm, is the pinnacle of those seeking to improve the effectiveness and efficiency of clinical practice, health care systems and services. Henderson and Eaton (2013) indicates that providing feedback which is important for enhancing learning in practice is not always valued by the broader clinical team. There is limited recognition or acknowledgement of the RN supervisor

who is required to consistently interact with students (HWA 2012; Gurling 2011). RN supervisors are thought to be inadequately acknowledged by health and universities, whose respect they seek (Walker, Cooke & McAllister 2008). This lack of reward and recognition works against legitimising the value of facilitating learning in practice (Barnett et al. 2004). The challenge is that health services focus on delivery of direct care and do not always recognise the importance of learning in practice. Consequently, roles in facilitating learning can often receive limited recognition. It is paramount though, that these roles are acknowledged as they make a crucial contribution to learning in the workplace (Gurling 2011). Learning in the workplace, cannot occur of course, if industry do not offer clinical placements to students.

Attitude and burden

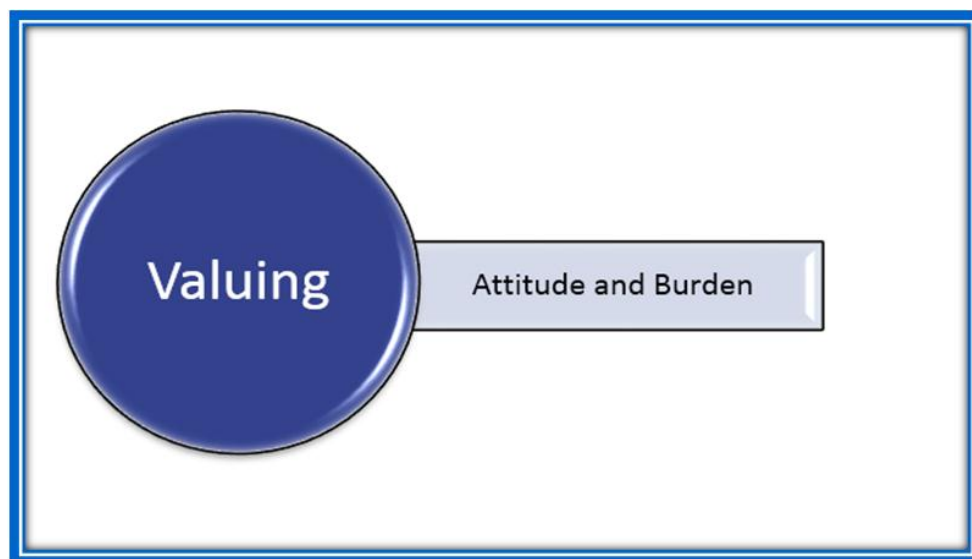


Figure 17: Valuing and major elements.

The relationships between supervising RNs and pre-registration nursing students are important influences on the placement experience and are determined by the value the organisation has, with regard to clinical placement of pre-registration nursing students in general (Courtney-Pratt et al. 2012).

Such relationships are perceived by pre-registration nursing students to make a difference in how confident they are in seeking advice and getting help. It is not uncommon to hear reports from students who felt it was made very obvious that some nurses had a negative attitude toward them attending clinical placement at their unit and did not want to help any of the students (Courtney-Pratt et al. 2012). Attitude is expressed as an inclination to act in response positively or negatively towards a certain situation (Lamont, Brunero & Woods 2015). Cohen (2011) proclaimed that an attitude is an important thing. It can shape the way the individual sees an experience and how observers see the individual and can entirely make or break an experience. Consequently, if students don't feel valued it may impact on relationships with preceptors and nurse unit managers, which may in turn impact on decisions made with regards to offering further placements to pre-registration students.

Such perceived negative attitudes could lead to pre-registration nursing students feeling nervous and incompetent. In the same mixed method study of the quality of clinical placements for second year pre-registration nursing students in an acute care hospital, several comments were also made by supervising ward nurses that it was not helpful if '... students were not enthusiastic to learn' or appeared to 'lack motivation' (Courtney-Pratt et al. 2012, p. 1386). Several words were used frequently by pre-registration nursing students and by supervising ward nurses to indicate characteristics of relationships which were valued by both groups. These words included *supportive, friendly, enthusiastic, welcoming, confident* and *comfortable*. Feeling part of the team was instrumental to receiving maximum benefits from the placement experience and positive relationships between pre-registration nursing students and supervising ward nurses were frequently mentioned by all participants as an important element of the placement (Courtney-Pratt et al. 2012).

In Australia, the RN is bound by national professional standards and competencies established by the ANMAC in 2006, now known as the NMBA (NMBA 2010). One requirement of the NMBA is that the:

RNs must be able to supervise, delegate, monitor, and evaluate others' performance in the workplace. The RN is also required to act as a resource person and provide safe, timely, and accurate direction for others; use a range of direct and indirect techniques, such as instructing, coaching, and mentoring; and collaborate in the supervision and support of others (NMBA 2010).

In addition, the NMBA requires the RN to be able to undertake formal and informal education sessions, using varied educational resources, and to communicate well with all members of the health care team. Additionally, they are expected to be able to provide constructive feedback to nurses who are being supervised or to whom care has been delegated (NMBA 2010). Given the extent of the support and educative role of the RN toward others, inclusive of students, it is important for RNs to have positive attitudes regarding teaching and supporting pre-registration students on clinical placement.

RNs who work with students in the clinical area and assist with their learning are commonly known as preceptors (Broadbent et al. 2014). Smedley and Morely (2010) assert within the context of nursing education in Australia, the RN preceptor plays an invaluable role with nursing students; yet many are not specifically trained for this role. When students are placed within a non-supportive clinical environment, their perceptions of nursing as a career can be influenced negatively (Elliot 2002) and their learning may be less than effective (Dickson, Walker, & Bourgeois 2006).

In line with the documented competencies, it is expected that the RN will perform the role of clinical supervision for pre-registration students and others as needed in the workplace. The Australian nursing work force has seen an increase in part-time employment as opposed to fulltime positions (HWA 2014a) and the consequence of this workplace mix is that there is minimal opportunity for the student to work consecutive days with the same RN preceptor.

Unavoidably, as a result, students are preceptored by a number of RNs who have different experience levels and care delivery, during any single clinical placement, offering little consistency in the student's experience. The significant part-time nature of the Australian nursing work force and the shift work scheduling of nurses can affect the student's ability to form quality relationships with individuals in the clinical setting. These challenges are not easy to overcome but serve to highlight the need for RN preceptors to have effective communication skills, knowledge, nursing skills, and a positive attitude toward students to form a quality short-term relationship.

The extent to which RNs provide the required degree of supervision is influenced by a number of factors. These include, the attitudes of RNs and their willingness or otherwise to work with students, communication from the University and the tempo of the unit and whether there was adequate time for supervision (Reid-Searl, Moxham & Happell 2010).

There have been reports of growing disquiet about clinical placements and the growing demands on working nurses to precept students while also caring for their patients (Carrigan 2012). Carrigan (2012) reasons that it is very challenging for nurses with many years of clinical expertise and very little, or no teaching experience, to mentor students.

Courtney-Pratt et al. (2012) claims that maintaining capacity to support pre-registration students is reliant on the development and maintenance of a healthy work environment where RNs feel valued and respected for the support they give pre-registration nursing students. Without a supportive work environment, offers of clinical placement are impacted on, and capacity is greatly reduced (Willis 2012). The personal qualities or attitudes that the preceptor brings to the role are instrumental in building an effective relationship with the student.

Engagement with the literature, as has occurred in this thesis, indicates that students are perceptive and know when they are perceived as a burden during their clinical placement.

Such attitudes can be attributed to not only the RN supervisor not valuing the opportunity to preceptor a student, but also from higher within the organisational culture. If health care providers value pre-registration education and practiced shared responsibility for producing competent nursing graduates, it could be assumed that such a culture would infiltrate all levels of nursing, from managers to clinicians.

There is a consensus that students need to be valued, supported, and encouraged in their learning within the clinical workplace (Henderson, Twentyman, Heel, & Lloyd 2006; Schmalenberg et al. 2008). Schmalenberg et al. (2008) identified that a caring attitude of industry staff included traits of being an advocate for students, welcoming students, including them, providing autonomy with appropriate preceptor presence, making human connections, and providing genuine feedback.

Undertaking a precepting role is acknowledged internationally as complex and challenging (McCarthy & Murphy 2010). Some studies such as that undertaken by Malik and Hunt (2007) and Levett-Jones and Lathlean (2008) have found that nursing students undertaking clinical placement within the currently challenged nursing climate are perceived to create a burden to an already stressed workforce. Managers within the units (wards) are aware of demands already placed on their clinical staff and as a result, the perception of further burdening their staff was identified to impact on offers of clinical placement to students.

A study that aimed to investigate the perceptions of clinical and senior managers about the role of practice educators (facilitators) employed in one acute hospital in the UK, by Malik and Hunt (2007) found students and their teaching needs were viewed as placing additional burdens on the existing pressures of hectic clinical workloads. A variety of solutions were offered to relieve the burdens placed upon staff. However, in general, the facilitators were viewed as relieving much of the day-to-day pressures placed upon nursing staff either by: lightening the burden of nurses in charge of wards in pursuing students not turning up for

work, relieving clinical managers in assisting students in resolving personal difficulties, or lightening the work load of nurses in clinical settings by caring for patients with students for a span of duty or undertaking drug rounds.

Supporting

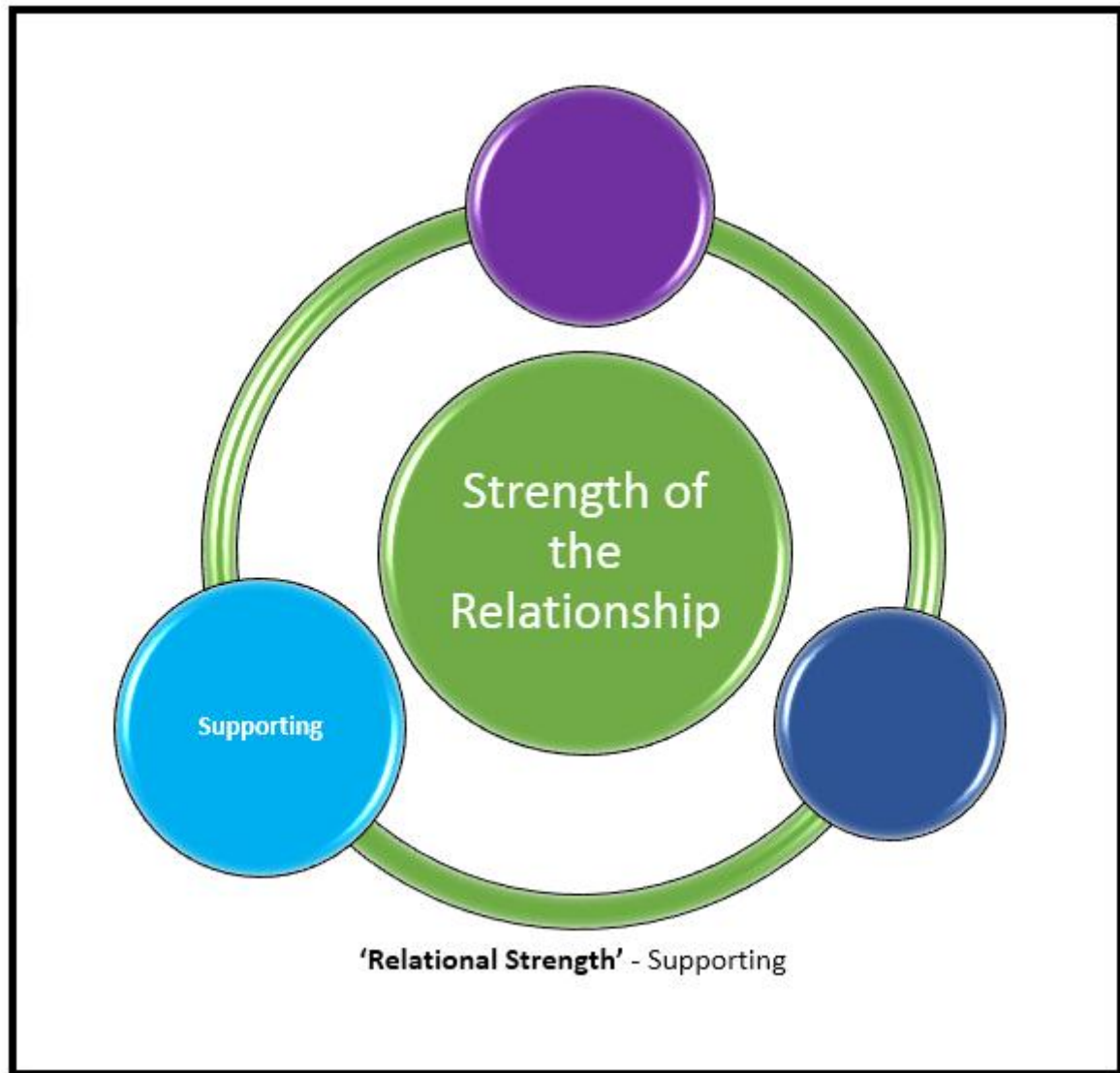


Figure 18: 'Relational Strength'—Supporting.

Courtney-Pratt et al. (2012) suggests CPPs are reliant on the development and protection of a unified work environment to maintain offers of clinical placement and a capacity to support pre-registration students. An environment is essential where RNs feel valued and respected for the support they give pre-registration nursing students. Recognising substantial workloads

of nursing staff as well as identifying the level of nursing experience on the ward, can assist in planning for pre-registration nursing students undertaking clinical placement. Further to this, employing the supervisory skills of a clinical facilitator, familiar with the academic learning outcomes of the clinical placement, in addition to having support for the RN supervisors, eases the concerns ward staff and facilities have. Almost all participants in this research identified levels of support as a major factor when considering offers of clinical placement within their facility.

Offering placements in busy clinical environments requires recognition by the organisation of the importance of learning. Leadership and management teams of CPPs need to prioritise learning in the context of clinical care (Henderson & Eaton 2013).

RN supervisors need to be prepared to effectively support learning in practice (Gurling 2011). When effectively prepared they can more successfully engage students and graduates into the ward context so that they feel a part of the team (Edgecombe & Bowden 2009). The situation is that many supervisors often do not know where to start when interacting with a student. They need preparation to be confident in their teaching role.

This presents a perfect opportunity for universities and CPPs to take dual responsibility in working together to provide education and support to the RN, whereby facilitating the possibility of maintaining and even increasing capacity of student placements. Health care providers can assist by providing opportunities to their RN staff for better and more comprehensive mentor preparation which may include general study leave duties (McInnes, Peters, Hardy & Halcomb 2015; Atkins & Williams 1995). Time for mentoring needs to be included within the working day. Mentoring responsibilities need to be fully taken into account in nursing establishments and personnel planning if the quality of both patient care and mentoring are to be maintained. Valuing mentoring as a staff development strategy

would encourage staff to undertake adequate preparation. It would also provide a feeling of support for the staff undertaking the role, rather than the feeling that the time spent with students ought to really be spent on other duties (Atkins & Williams 1995). Universities could offer education packages and workshops to the CPPs as an in-kind recompense and goodwill gesture within the partnership. Educating RNs in the clinical supervision of students is of utmost importance. Reid-Searl and Happell (2011) indicated that without educated supervision and support, and in consideration that all RNs have a duty to supervise pre-registration students, offering clinical placements to pre-registration nursing students may pose a risk to patient safety and organisational well-being, if clinical placement supervision is not valued.

Clinical placements for students need to be supported, in order to meet the needs of growing service demands (Hall-Lord et al. 2013, Courtney-Pratt et al. 2012). Common factors of support are required for pre-registration and supervising nurses regardless of setting and country (Courtney-Pratt et al. 2012). Some of these factors include the health care environment, workload and skill mix and the supervisee-supervisor relationship (Hall-Lord et al. 2013). Courtney-Pratt et al. (2012) also identified other elements such as recognition of professional responsibility to the future nursing workforce and education opportunities in student supervision, as supportive factors in the clinical placement arena.

It is accepted that the primary responsibility of the RN is the delivery of the highest standards of nursing care to patients. Nonetheless, as professionals, and as previously alluded to, they also have a responsibility to support the learning of other nurses (Courtney-Pratt et al. 2012).

The Australian National Competency standards for the registered nurse state that RNs contribute to quality health care through lifelong learning and professional development of themselves and others, research data generation, clinical supervision and development of policy and clinical practice guidelines. The NMBA states, there is a professional commitment

of nursing staff to support the next generation of nurses. This competency insists that RNs participate where possible in precepting, coaching and mentoring to assist and develop colleagues and must participate where appropriate, in teaching others including students of nursing and other health disciplines, and inexperienced nurses.

If RNs are mandated to supervise and support pre-registration students, then it could be argued, that these supervisory nurses must be given the support and education to enable them to undertake such a role. Courtney-Pratt et al. (2012) indicates the opportunity to develop knowledge of nursing practice through clinical experience is clearly an important component of the pre-registration placement, but also the opportunities for supervising ward nurses to extend their knowledge, and skills in supporting other nurses to learn is of equal value.

The quality of the relationship between the student and their RN directly affects the outcome of the student (Brammer 2008). A common behaviour of RNs noted by Brammer (2008) which impede student learning, includes a lack of confidence in their support role for students. Supervisors feel they are not adequately prepared for the role with pre-registration nurses. Brammer (2008) found the complexity of the RN role with students and the dependence students placed on their RN buddies, suggests that adequate professional development in the area of supporting clinical learning for all RNs needs to be a priority. There will always be informal encounters between RNs and students, so acknowledging such relationships and preparing RNs with a foundation for their role is essential.

Henderson and Eaton (2013) found RN supervisors are not always assisted to facilitate student learners. RNs are often poorly prepared to take on the role of preceptor or mentor (Henderson & Eaton 2013; Hamshire, Willgoss & Wibberley 2012). Many RNs who are commonly asked to take on these roles, are selected due to their clinical experience rather than their education preparation or ability to facilitate learning (Paton & Binding 2009).

Insufficient training and preparation for preceptors is problematic and the ability to make clear and reliable judgements about learners' performance is significantly inhibited when preparation and continuing development is limited (Henderson & Eaton 2013).

Workload and supervision

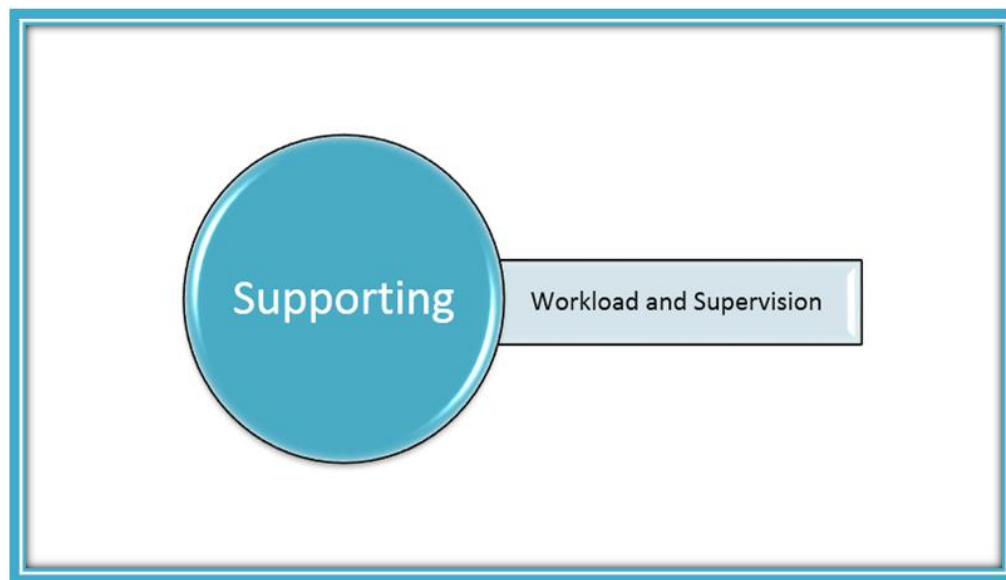


Figure 19: Supporting and major elements.

Nurses are reported to be working beyond expectations to endeavour to meet patient needs during a regular shift and supervising clinical placement of pre-registration students is thought to add to their tasks in a shift. The nursing workforce shortage in Australia is well documented (NHWT 2009; HWA 2012), with a predicted shortfall of approximately 40,000 nurses in Australia over the next 10 years (Bennett et al. 2012). This shortage will contribute to feelings of being overworked; which are already audible. This Master's study found that RNs already struggle to navigate heavy workloads and that nurse managers consider the demand already placed on their RNs before offering clinical placement to pre-registration students.

Precepting nursing students can be a complex role for RNs (Broadbent et al. 2014). During the preceptor role several challenges need to be overcome, with lack of allocated time for

precepting appearing to be a primary concern. Scarcity of allocated time for precepting has been reported in some studies (Carlson et al. 2009). When nurses experienced time shortages because of heavy work load, supervising students was considered stressful. Due to a high workload, clinical nurses often lack time for general patient care as well as planning of their daily work. No time is usually scheduled for supervision of students. In addition, collaboration with faculty members which can be required if students are on the ward, can also intrude on patient care, and adds to the workload of staff (Hall-Lord 2013).

Supervising as an educational process must be recognised and efforts made to allocate protected time for this important role. Close cooperation between all stakeholders engaged in clinical nursing education is recommended to ensure that precepting is acknowledged as an integrated nursing competence. Given the unrelenting pressures on the health service generally, supporting pre-registration nursing students during clinical placement has become a challenge for nurse educators, nurse managers, and supervising ward nurses who are given the direct responsibility for service delivery and providing clinical support, supervision and evaluation to undergraduates (Courtney-Pratt et al. 2012). Significantly, in addition to supporting pre-registration nursing students, nursing teams are also requested, and expected, to support medical students, paramedics, diploma nursing students, physiotherapists, and a range of other personnel.

Henderson and Eaton (2013) identifies that further to preparation, there appears to be a lack of understanding by management regarding the time taken by RNs to assist students. This exacerbates workload issues with preceptors reporting increased work intensity when management support is low (Billet 2003). Preceptors who have indicated that although they feel adequately prepared to undertake the position, they do not always feel that management provide support for them to undertake the role. By not effectively rostering, or allowing the time that is required to discuss clinical situations and provide feedback, preceptors believe

this exposes a lack of support (Henderson et al. 2006). Protected time is required to provide feedback to learners (Gurling 2011) and RNs recognise they require support through time allocation, to undertake this part of the job effectively.

Managers unaware of the work required of preceptors, may exacerbate workload issues through assigning additional duties as they believe that the student provides extra help (Yonge et al. 2002). Yet, the demands of clinical practice can consume time (Henderson et al. 2011; Chuan & Barnett 2012). Of significance to maintaining quality care is when preceptors are reluctant to give accurate appraisals about poor performance (Larocque & Luhanga 2013; Rutkowski 2007). They do not wish to assume the extra workload involved in documenting their decisions about such performance yet this is an important aspect of providing feedback to the student. In addition, as gatekeepers to the profession, preceptors and faculty have a duty to ensure that only students with appropriate knowledge, skills, and values necessary to serve patients are admitted to professional practice, thereby protecting society from incompetent or unsafe practitioners (Larocque & Luhanga 2013).

This Master's study found that when managers felt they did not have the appropriate staffing experience and expertise within their department, they opted not to offer clinical placements to pre-registration nurses. This was considered a safety precaution, to ensure that patient care was prioritised over the supervision of students. While learning opportunities for nursing students are important, this must occur according to processes and procedures that maintain the safety and wellbeing of patients (Reid-Searl et al. 2010).

Skill mix in nursing can be classified as the most appropriate mix of staff required to provide safe quality care and is a critical aspect of workforce planning and utilisation (NSW Health 2010). In Queensland, a state in Australia, there is believed to be a continuing inadequate skill mix to meet the daily needs of patients (Cubit & Ryan 2011). Lack of RNs, too few

relief staff and funding shortfalls are the major contributing factors to an inappropriate skill mix resulting in a negative impact on nursing and midwifery workloads (Hegney et al. 2008).

Replacing RNs with unregulated workers may yield immediate cost savings, but will have long term implications on the provision of safe, quality care, staff services and the effectiveness of our national health system (Cubit & Ryan 2011). Employers must be responsible for ensuring appropriate skill mix and models of nursing and midwifery and minimising the risk to patients through increased staff churn. Evidence confirms a direct relationship between the registered nurse and midwifery workforce and positive patient outcomes (Duffield et al. 2005). The World Health Report 2000 '*Health systems: improving performance*' suggests that determining and achieving the proper mix of health personnel are major challenges for most health care organisations and health systems. Health care is labour-intensive and managers strive to identify the most effective mix of staff that can be achieved with the available resources, taking into consideration local priorities.

The clinical placement of pre-registration nursing students prepares students for clinical work as a registered nurse (Walker, Cooke, Henderson & Creedy 2013). The clinical placement must enhance the student's engagement in a clinical situation and increase their ability to apply clinical reasoning to a situation (Benner, Stephen, Leonard & Day 2010). Clinical placement of pre-registration nursing students aims to provide students with a link between theory and clinical practice. The student is exposed to a range of clinical scenarios, all with an undetermined trajectory, unlike the class room setting. These clinical situations, under the guidance of RNs, provide the student with opportunities to develop clinical reasoning (Benner et al. 2010). Within these clinical placements, the RN provides both supervision and guidance on the procedures and expectations of their respective clinical areas (Coyne & Needham 2012).

Clinically proficient nurses are notable from their colleagues by their ability to make critical clinical decisions while comprehending the whole nature of a situation (McHugh & Lake 2010). Expertise influences nurses' clinical judgment and quality of care and develops when a nurse tests and refines both theoretical and practical knowledge in actual clinical situations (McHugh & Lake 2010).

Within the context of the recognised global nursing shortage and particular localised pressures within health services, questions of appropriate nurse staffing levels and skill mix are once again becoming increasingly important. It would seem that the determination of optimum nurse staffing levels and skill mix is a central issue in relation to health service governance, service user involvement, as well as in the recruitment, retention and well-being of nursing staff across the service sectors (Flynn & McKeown 2009). Sprinks (2014) reports in the *Nursing Standard*, a UK nursing journal, that Guy's and St Thomas' NHS Foundation Trust chief nurse, Eileen Sills, suggests that staffing numbers are just a tiny bit of the picture. Sills stated in the Sprinks interview 'I am more interested in the skills of the staff on duty when addressing staffing shortages.' The Guy's and St Thomas' NHS Foundation Trust hospitals offer clinical placement to approximately 600 nursing students a year.

After the transfer of nursing education to universities, the students' time for learning in the clinical setting has decreased in many Western countries, as has the nurse lecturers' supervision of students in direct patient care. The lecturers' role has changed from supervising students in hands on nursing to focussing more on nursing theory and research (Barrett 2007). Clinical supervision has to a great extent, become the responsibility of clinical nurses, who are already overwhelmed with patient duties, often insufficiently prepared for the supervisor role and unaware of educational goals (Lambert & Glacken 2005). Due to the heavy work-load of clinical nurses, students often are left to themselves in their clinical placements (Brammer 2008; Hall-Lord 2013).

Nursing is a discipline that requires substantial levels of clinical training prior to registration, and this professional experience in the health care context is vital for developing professional competencies. HWA (2014a) propose clinical placements involve nursing students working under supervision in a specific healthcare setting, with the aim of providing the link between theoretical knowledge and practical application in a supportive environment. HWA (2014a p. 13) further state ‘...the assessment of competence within the context of clinical placement needs to be undertaken by an appropriately qualified Registered Nurse’.

There are a number of models of clinical supervision in nursing as described by HWA (2014b). These include the preceptor, facilitator, combined facilitation-preceptorship model, a dedicated clinical placement unit model and the mentor model (HWA 2014b). Even though the provision for preceptorship training exists, and is encouraged, it is not mandatory for the supervising ward nurses to complete the course prior to supporting pre-registration nursing students (Courtney-Pratt et al. 2012).

The Australian College of Mental Health Nurses (ACMHN) (2010) describes the clinical supervision by RNs as a core component of contemporary professional nursing practice. If the relationship between the student and supervising ward nurse is successful, it benefits all involved. When it is less than successful, it can be frustrating and can result in student disillusionment about nursing and an inability to integrate and learn (Yonge et al. 2002; Walker et al. 2013). Yet it is also suggested that support, feedback and acknowledgement of supervising ward nurses is easily overlooked and may contribute to burnout in that group (Allen & Simpson 2000).

Courtney-Pratt et al. (2012) discusses that nurses now find that a shift without a student is the exception rather than the rule. This affirms the valuable role they undertake in student learning. As such, it is worthwhile to provide feedback and support to supervising RNs by

communicating recognition of the quality clinical placement they are partners in providing (Courtney-Pratt et al. 2012).

Tuohy (2011) identifies that the Nursing Council of New Zealand (NCNZ) requires that healthcare institutions offer clinical placement opportunities to nursing students and provide them with a quality educational experience. This includes facilitation of appropriate learning opportunities and workload, and the availability of RNs willing and able to teach the students. These learning experiences need to be supported by organisational processes and administrative procedures in the form of a clinical education support agreement or Memorandum of Understanding (MOU) between the tertiary provider and the healthcare provider (Touhy 2011). Some of the consequences of this shift include increased demands placed on nurses supervising students, and the perception that academics are guests, or are invisible in the clinical setting.

The primary aspect of the clinical facilitators' role is to give support to students. It is their core business, whereas nurses are primarily responsible for patient care and support students as part of their clinical activities (Courtney-Pratt et al. 2012). Lambert and Glacken (2005) lament that a considerable lack of role clarity resides over what constitutes clinical facilitation and the role of the clinical facilitator. Thus, it is paramount to strengthen this support role (Lambert & Glacken 2005). RNs who supervise nursing students in clinical settings also indicated that the clinical facilitators' role was instrumental in providing them with support. As one nurse noted 'It was beneficial that the clinical facilitator came around every day to support the students and also the preceptors' (Lambert & Glacken 2005, p. 666). Such assistance was welcomed when there were 'heavy workloads and time constraints' identified to impact on the ability of the supervising ward nurse to give time with undergraduates' (Courtney-Pratt et al. 2012, p. 7).

The clinical facilitator's role focuses on the students' learning needs and competence in clinical practice and the need for such a role in supporting students is not under debate (Williamson & Webb 2001). Clinical facilitators are valued most when the clinical areas are particularly busy, when students have problems and for formal critical reflection (Courtney-Pratt et al. 2012).

Given the promised investment in high quality professional placements by Health Workforce Australia there should be potential to formalise the roles and career options for clinical facilitators and to give more support and specific preparation for them (Courtney-Pratt et al. 2012). It was expressed by the participants of this Master's research, that a University supervisor makes a positive difference for supporting both the RN and student. By supporting the supervising RNs, CPPs feel they can offer more clinical placements to pre-registration nurses, as the workload and precepting duties will not negatively impact on patient safety or staff.

The substantive theory for this Master's research is '**Relational Strength**'. This theory asserts that the primary influence when offering clinical placement for pre-registration nursing students is the **Strength of the Relationship** between the universities and the CPP.

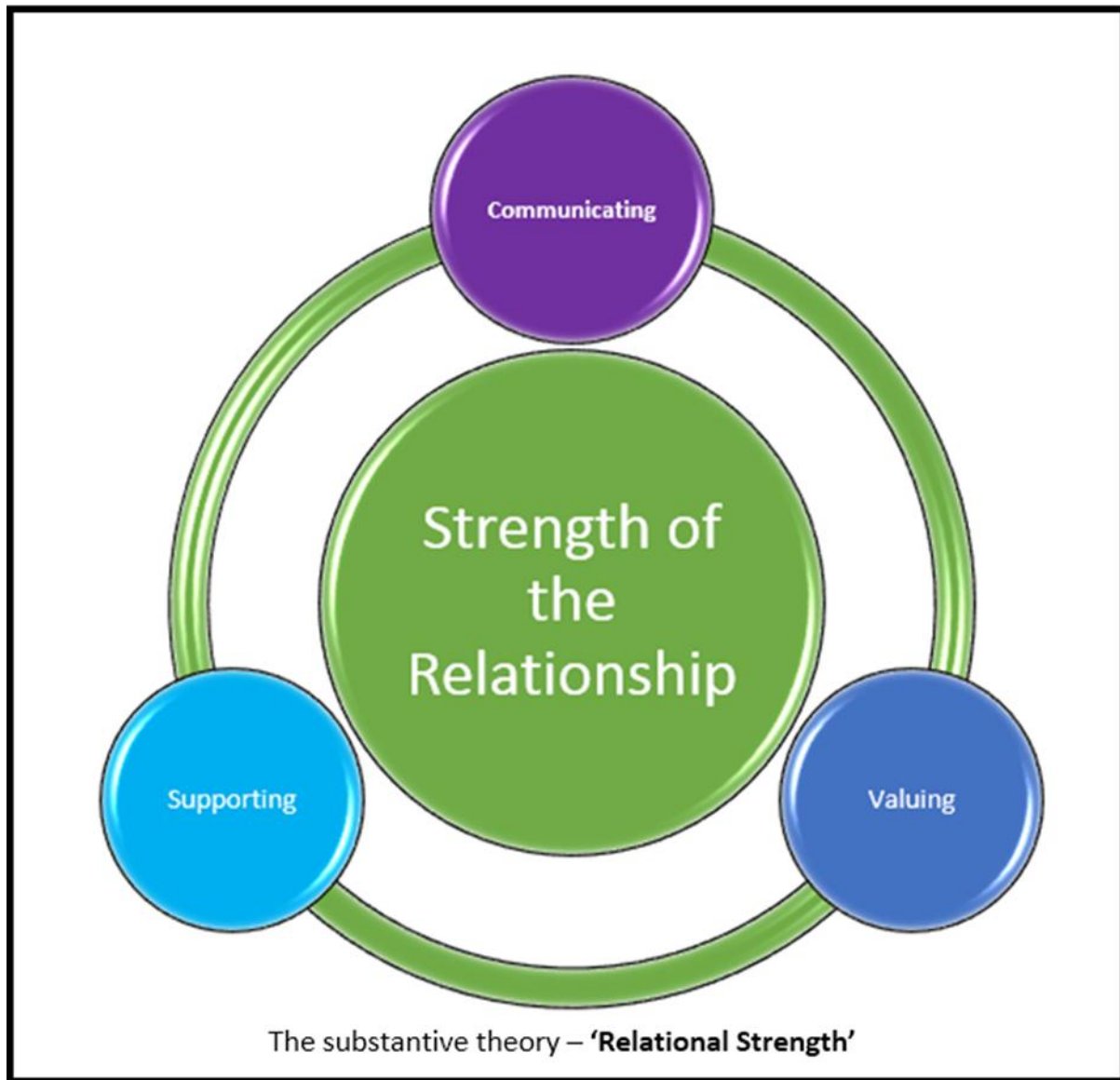


Figure 20: 'Relational Strength'.

Although a Master's study does not have to contribute new knowledge per se, this research has. '**Relational Strength**' provides new insights and understanding into the elements required to maintain a strong relationship between universities and CPPs in pre-registration nursing education in the Australian context. Findings from the data show that universities need to have a strong relationship with their industry partners, the CPPs, to ensure clinical placements continue to be offered.

The data revealed the emergence of the central category; **Strength of the Relationship**.

Strength of the Relationship asserts that through effective communication and meaningful

partnerships, hurdles can be overcome, miscommunications righted and positive interactions will be remembered before negative ones. The central category is informed by three major elements, Communicating, Valuing and Supporting. These elements describe the factors that impact on **Strength of the Relationship**, and in turn, clinical placement offers for pre-registration nursing students.

Of great importance, this Master's study of *What influences industry to offer clinical placements for pre-registration nursing students?* uncovered that communication and collaboration between the Universities and the CPP is central to securing clinical placements for pre-registration nursing students. The widespread use of clinical placement during pre-registration education highlights the necessity of forging successful relationships with industry (Jeffries & Milne 2014). Universities are entrusted with producing health care graduates that are competent and able to adapt to changing clinical environments (ANAMC 2009) but they do not do this in isolation and clinical experiences are integral to achieving this aim.

This study identified that by maintaining strong communication and a collaborative partnership between the CPP and universities, could ensure students' needs are provided for during placement. Without a meaningful partnership, offers of clinical placement can be impacted on, as the onus of the placement is felt individually by the health care facility and becomes perceived as burdensome to the organisation. Producing nurses who are fit for practice, purpose and academic award is a key issue for nurse education partnership providers (Malik & Hunt 2007). The continued offers of appropriate and quality clinical placement to pre-registration nursing students, has to occur in order to achieve this aim.

This study found collaborative partnerships result in the creation of a distinct culture that values and integrates the unique characteristics of each partner's core business. Partnerships

between universities and healthcare providers that recognise the mutual benefits and strengths that are derived from an alliance have become of increasing importance. Both members of the partnership must value and respect the relationship.

Importantly, maintaining capacity to support pre-registration students is reliant on the development and maintenance of a healthy work environment, where RNs feel valued and respected for the support they provide to pre-registration nursing students. As Willis (2012) asserts, a supportive work environment is of utmost importance and without it, offers of clinical placement are impacted on and capacity effected.

This study also found that RNs on the floor already struggle to navigate heavy workloads and that managers need to consider this at length before offering clinical placement to pre-registration students as they perceive students add to the day to day workload of the RN. Participants stated that when they did not have the appropriate staffing experience and expertise within their department, they opted not to offer clinical placement experience to pre-registration nurses. This was considered a safety precaution, to ensure the patient care was prioritised over the supervision of students.

This chapter has situated the identified substantive theory '**Relational Strength**' (as shown in Figure 20) and research results within the context of the existing literature. It has validated the findings in relation to the participant perceptions regarding their beliefs of *What influences clinical placement providers to offer clinical placements for pre-registration nursing students?* including the elements of Communicating, Valuing and Supporting. The final chapter presents concluding statements, recommendations for consideration and future research and final reflections.

CHAPTER SIX

Recommendations, limitations and final reflections

The aim of this research was to understand *What influences industry to offer clinical placements for pre-registration nursing students?* and concomitantly contribute to an understanding of why clinical placements are not offered. Through achievement of the aim and the development of the substantive theory guided by Grounded Theory research design, valuable insights have been gained to assist in ensuring clinical placements continue to be offered for pre-registration nursing students.

The substantive theory developed as a result of this Master's research is the Theory of '**Relational Strength**'. This substantive theory asserts that the primary influence when offering clinical placement for pre-registration nursing students is **Strength of the Relationship** between the universities and the CPP. This substantive theory provides insight and understanding into the elements required to maintain a strong relationship between universities and CPPs in pre-registration nursing education. As elucidated in the previous chapter, Universities desire a strong relationship with their industry partners, the CPPs, to ensure appropriate clinical placement opportunities continue to be offered.

The chapters prior to this final one, presented an introductory overview, the background and context to the study. A full elucidation of the research design, the findings that emerged as a result of the constant comparative method of data analysis and then a comprehensive discussion of those findings within the context of the existing literature in this area also occurred. To conclude this thesis, the contribution to nursing knowledge, existing limitations, recommendations arising from this research as well as recommendations for future research will now be addressed.

Theoretical contribution to knowledge and recommendations

This study is distinct in that it explored an area of pre-registration nursing education that has not been studied in depth. This is demonstrated by a silence within the literature, in relation to what influences industry to offer clinical placements to pre-registration nursing students. The findings provide insight into the many issues described by participants with regard to why (and why not) they offer clinical placements. In the process of achieving the research aim, areas where improvements could be targeted, have been identified.

The data revealed the emergence of the central category; **Strength of the Relationship**. The **Strength of the Relationship** illustrates that through effective communication and meaningful partnerships, hurdles can be overcome, miscommunications righted and positive interactions will be remembered before negative ones. Key findings revealed that the central category is informed by three major elements, Communicating, Valuing and Supporting. These elements describe the factors that impact on **Strength of the Relationship**, and in turn, clinical placement offers for pre-registration nursing students.

The findings offered in this thesis are subject to further research using a variety of methods and methodologies. Some specific areas identified that may add value to the knowledge about clinical placements as a distinct contributor to the education of BN students are listed below.

The overarching goal is to develop and maintain a strong relationship in relation to curriculum and end product expectations. This could be achieved by the following;

- Regular and collaborative engagement between universities and industry demonstrated by meeting as a reference group to inform and explore contemporary issues in higher education and industry.
- Nominate a liaison person/team to build relationships.
- Seek information from pre-registration nursing students by convening a student clinical placement reference group.

- Reward and acknowledge clinical staff for mentoring/preceptoring/facilitating students.
- Encourage nurses who express an interest to develop and enhance their skills for clinical teaching.
- Ensure one primary contact person from the University is available to trouble shoot/support industry staff to decrease the negative impact or implied burden of having pre-registration nursing students.
- Offer professional development sessions to interested clinicians at no cost, on topics such as student facilitation, adult learning and mentoring peers.

Recommendations for further research:

The potential for this substantive theory to find application in a diverse range of practice settings could be achieved by undertaking the following research:

- Exploring the notion of ‘Dual Responsibility’ in the education and enculturation of RNs in Australia.
- Does patient safety and positive outcomes improve when clinical placement in pre-registration education is greater?
- Compare and contrast ‘Burden or Benefit’ of facilitating/preceptoring students.

Limitations

The inquiry that progressed throughout this Master’s study had to be contained and had to have an end point. As such, it is important to recognise that there are many other avenues of inquiry that could have been pursued and that all research endures limitations (Ioannidis 2007). Although this research was conducted within acceptable standards of credibility, as previously discussed in Chapter four, it too, is not without limitation.

This study used an exploratory approach to generate a substantive theory. The number of participants $n=9$, was small and purposively selected. It was also purposively contained within the geographical area of Central Queensland, Australia. Despite this containment, Central Queensland still covers an area of 42 7937 sq. km. A sample size of this quantity is acceptable within qualitative research which aims for understanding and not generalisability. That said, the inability to be able to generalise results, will be seen by some as a limitation.

Also it must be considered that this study has given voice to only one side of university and industry partnerships in relation to offers of clinical placement for pre-registration nursing students, and therefore this may be viewed as a limitation. It could also be counter argued that examining one side of this story is not a limitation because industry stakeholders are in a position of power in this relationship as they are the providers of the sought placements and therefore are the dominant partner. This encourages the researcher to seek clarity to the question, who is most responsible for taking the initiative in developing strength in the relationship/ meaning in the partnership? Hence further recommendations for research included the exploration of 'dual Responsibility' within nursing education in Australia.

Researcher final reflections

The research and resulting substantive theory presented in this Master's' thesis is limited by the researcher being a novice. Was it adventurous for a novice researcher to use Grounded Theory? Possibly, and I acknowledge that. I did however, want to extend myself and go beyond descriptive methods by working toward theory generation so as to explore the phenomenon of interest at a higher level of conceptualisation. I think the risk was worth it and I have learned so much. During the journey, every attempt was made to ensure that credibility and reliability were adhered to. With the experience gained from this research, confidence in using this methodology in the future has increased. I feel as though I can place

greater trust in myself as a researcher and more fully appreciate the importance of letting the emergence of concepts come from the data.

Nursing is a discipline that requires substantial levels of clinical placement and professional experience prior to registration. Nursing education is now undertaken at tertiary level in Australia and has been so for three decades. As a consequence, clinical placement is required for students to integrate practice of nursing theory in real life settings.

This study yielded rich qualitative data that revealed that understanding *What influences industry to offer clinical placements for pre-registration nursing students?* will afford universities valuable information. Participant voices were used extensively to enable the results to be presented through the lens of the participants and also acknowledge their expertise. Information of this importance will assist in ensuring appropriate clinical placements continue to be offered for pre-registration nursing students by industry.

It is believed that the findings of this research (including the substantive theory) will contribute to clinical placement availability through the development of strong beneficial relationships between pre-registration universities and clinical placement providers.

Implementation of the recommendations discussed above could ultimately impact positively on overall clinical placement provision and contribute to enhancement of working relationships between universities and CPPs within Australia.

Working with the persons in industry who make the decision to offer or decline clinical placements to universities for their BN students was an enlightening and gratifying experience. It was the participants' comprehensive contributions that enabled identification of the substantive theory to explain influencing practices and ultimately answer the research question and it is hoped that this contribution to current knowledge will make a difference.

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Appendix A

Initial Application Approval



INITIAL APPLICATION APPROVAL -Transfer

In reply please quote: HE12/110

Further Enquiries Phone: 4221 3386

28 May 2012

Ms Justine Connor
School of Nursing and Midwifery
Building 18, Rm1.10
CQ University
Bruce Highway
NORTH ROCKHAMPTON QLD 4701

Dear Ms Connor,

I am pleased to advise that the application below has been approved.

Ethics Number: HE12/110
Project Title: Factors that influence industry to offer clinical placements for undergraduate nursing students.
Researchers: Ms Justine Connor, Professor Lorna Moxham, A/Professor Kerry Reid-Searl
Approval Date: 5 April 2012
Expiry Date: 4 May 2013

The University of Wollongong/ISLHD Health and Medical HREC has noted the previous Central Queensland University Human Research Ethics Committee approval (Project H11/11-170) and the transfer of the research to University of Wollongong.

The University of Wollongong/ISLHD Health and Medical HREC is constituted and functions in accordance with the NHMRC *National Statement on Ethical Conduct in Human Research*. The HREC has reviewed the research proposal for compliance with the *National Statement* and approval of this project is conditional upon your continuing compliance with this document.

A condition of approval by the HREC is the submission of a progress report annually and a final report on completion of your project. The progress report template is available at <http://www.uow.edu.au/research/rso/ethics/UOW009385.html>. This report must be completed, signed by the appropriate Head of School and returned to the Research Services Office prior to the expiry date.

As evidence of continuing compliance, the Human Research Ethics Committee also requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforeseen events that might affect continued ethical acceptability of the project.

Please note that approvals are granted for a twelve month period. Further extension will be considered on receipt of a progress report prior to expiry date.

Research Services Office University of Wollongong NSW 2522 Australia
Telephone: +61 2 4221 3386 Facsimile: +61 2 4221 4338
research-services@uow.edu.au www.uow.edu.au/research

If you have any queries regarding the HREC review process, please contact the Ethics Unit on phone 4221 3386 or email rso-ethics@uow.edu.au.

Yours sincerely,

Associate Professor Sarah Ferber
**Chair, UOW & ISLHD Health and Medical
Human Research Ethics Committee**

cc: Professor Lorna Moxham
School of Nursing, Midwifery and Indigenous Health

Renewal Approval 8 April 2013



RENEWAL APPROVAL

In reply please quote: HE12/110

Further Enquiries Phone: 4221 3386

8 April 2013

Ms Justine Connor
School of Nursing and Midwifery
Building 18, Rm 1.10
CQ University
Bruce Highway
NORTH ROCKHAMPTON QLD 4701

Dear Ms Connor

Thank you for submitting the progress report. I am pleased to advise that renewal of the following Human Research Ethics application has been approved. This certificate relates to the research protocol submitted in your original application and all approved amendments to date.

Ethics Number:	HE12/110
Project Title:	Factors that influence industry to offer clinical placements for undergraduate nursing students.
Name of Researchers:	Ms Justine Connor, Professor Lorna Moxham, A/Professor Kerry Reid-Searl
Approved from:	5 April 2013
Expiry Date:	4 April 2014

Please note that approvals are granted for a twelve month period. Further extension will be considered on receipt of a progress report prior to expiry date.

This certificate relates to the research protocol submitted in your original application and all approved amendments to date. Please remember that in addition to completing an annual report the Human Research Ethics Committee also requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforeseen events that might affect continued ethical acceptability of the project.

Yours sincerely

Associate Professor Sarah Ferber
Chair, UOW & ISLHD Health and Medical
Human Research Ethics Committee

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone (02) 4221 3386 Facsimile (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

Renewal Approval 1 April 2014



RENEWAL APPROVAL

In reply please quote: HE12/110
Further Enquiries Phone: 4221 3386

1 April 2014

Ms Justine Connor
School of Nursing and Midwifery
Building 18, Rm 1.10
CQ University
Bruce Highway
NORTH ROCKHAMPTON QLD 4701

Dear Ms Connor

Thank you for submitting the progress report. I am pleased to advise that renewal of the following Human Research Ethics application has been approved. This certificate relates to the research protocol submitted in your original application and all approved amendments to date.

Ethics Number:	HE12/110
Project Title:	Factors that influence industry to offer clinical placements for undergraduate nursing students
Name of Researchers:	Ms Justine Connor, Professor Lorna Moxham, A/Professor Kerry Reid-Searl
Renewed from:	5 April 2014
Expiry Date:	4 April 2015

Please note that approvals are granted for a twelve month period. Further extension will be considered on receipt of a progress report prior to expiry date.

This certificate relates to the research protocol submitted in your original application and all approved amendments to date. Please remember that in addition to completing an annual report the Human Research Ethics Committee also requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforeseen events that might affect continued ethical acceptability of the project.

Yours sincerely

A/Professor Sarah Ferber
Chair, UOW & ISLHD Health and Medical
Human Research Ethics Committee

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone (02) 4221 3386 Facsimile (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

Renewal Approval 20 March 2015



RENEWAL APPROVAL

In reply please quote: HE12/110

Further Enquiries Phone: 42 21 3386

20 March 2015

Ms Justine Connor
School of Nursing and Midwifery
Building 18, Rm1.10

Dear Ms Connor,

Thank you for submitting the progress report. I am pleased to advise that **renewal** of the following Human Research Ethics application has been **approved**.

Ethics Number: HE12/110
Project Title: Factors that influence industry to offer clinical placements for undergraduate nursing students
Researchers: Ms Justine Connor, Professor Lorna Moxham, A/Professor Kerry Reid-Searl
Date Approved: 20 March 2015
Renewed From: 5 April 2015
New Expiry Date: 4 April 2016

Please note that approvals are granted for a twelve month period. Further extension will be considered on receipt of a progress report prior to the expiry date.

This certificate relates to the research protocol submitted in your original application and all approved amendments to date. Please remember that in addition to completing an annual report the Human Research Ethics Committee also requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforeseen events that might affect continued ethical acceptability of the project.

A condition of approval by the HREC is the submission of a progress report annually and a final report on completion of your project. The progress report template is available at <http://www.uow.edu.au/research/ethics/UOW009385.html>. This report must be completed, signed by the appropriate Head of School and returned to the Research Services Office prior to the expiry date.

If you have any queries regarding the HREC review process, please contact the Ethics Unit on phone 4221 3386 or email rso-ethics@uow.edu.au.

Yours sincerely,

Professor Colin Thomson
Chair, UOW & ISLHD Health and Medical
Human Research Ethics Committee

The University of Wollongong/illawarra and Shoalhaven Local Health District Health and Medical HREC is constituted and functions in accordance with the NHMRC National Statement on Ethical Conduct in Human Research.

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone: (02) 4221 3386 Facsimile: (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

Appendix B

Participant Information Sheet

University of Wollongong



Participant Information Sheet – Clinical Placements

Principal Investigator: Justine Connor

Address: Bldg 18, CQUniversity, Bruce Hwy Rockhampton, 4701.

Research Project:

Thank you for taking an interest in this research. This project is part of my Master's degree which is specifically examining what influences industry to offer clinical placements.

What is required to participate?

Participation in this research is on a purely voluntary basis. You can withdraw from this study at any time. To be involved in this research you will have a private one to one interview with me. The interview will be taped and will take approximately 1 hour. This interview will be conducted at a time and place convenient to you.

During this interview I will not make any judgments about your responses. I am interested in what influences industry to offer clinical placements only. All information that you provide will not be identifiable. If you happen to mention names or places during the interview, these will be removed when the data is transcribed onto paper. Taped interviews will be kept electronically and stored on password protected computer in my office. This is to ensure your confidentiality at all times.

How to participate in this research

Please complete the attached consent form and return it to me in the replay paid envelope at your earliest convenience.

Ethical Approval

This study has been approved by CQUniversity's Ethics Committee (transferred to UOW 28/05/12). If you have any concerns about this study please contact the Office of Research on ph. 07 49232603, email ethics@cqu.edu.au. If you would like to receive the results of this research, a summary of the findings will be sent to you on completion of the study. Please indicate this on the consent form.

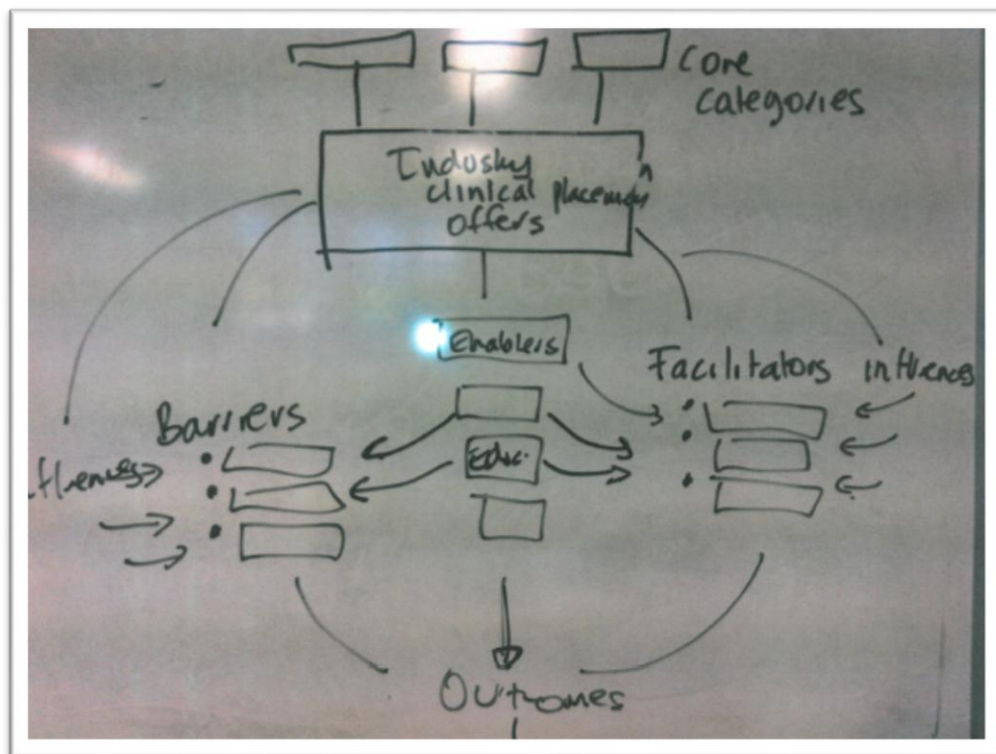
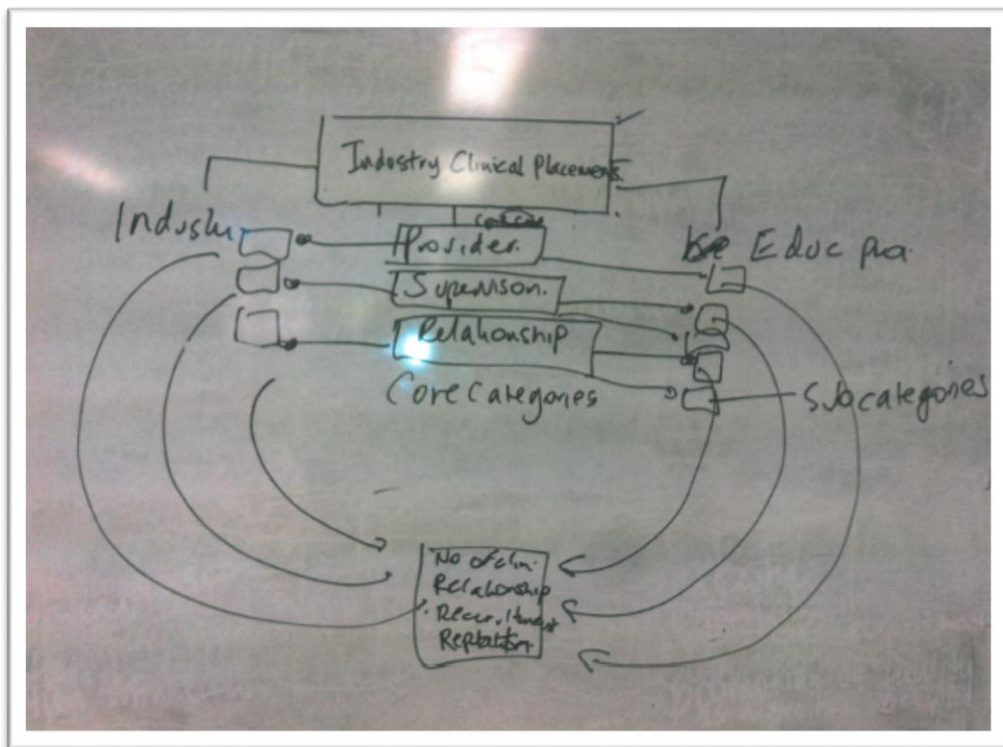
Thank you for taking the time to read this Participant Information Sheet. Please feel free to contact me on ph. or email me at j.connor@cqu.edu.au if you have any questions.

Yours sincerely

Justine Connor RN

Appendix C

Data Analysis examples and mind maps



Education Provider

- Timing of **Request**
- Amendments/cancellation
- Supervision Model
 - TYPE of supervisor role
 - direct supervisor
 - external consultant
- Relationship of EP to facility
- STUDENTS = ATTITUDE
COMMITMENT
- OUTCOME:**
 - potential recruitment
 - promotion of facility as a positive workplace
 - feeling valued
 - social acknowledgment - opportunity

Hospital/Facility

Model of Care

Staff w/loads - overload
- underload (exp)

Skill mix

Education focus of facility

- Importance of having students
- need for professional development

Look after your OWN!!

Resources available. Predicting
quality
practice

OTHER

Geographical area of

Competition with other EP/RTO's



Justine Mercia Connor

What influences industry to offer clinical placements for pre-registration nursing students?

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